Impotence in the Male

Carcinoma of the Gallbladder

Cancer of the Breast

Nickel Dermatitis

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EDITORIALS

The Great Chiropractic Enigma

WE have no doubt that the new Governor of the State of New York, noted symbol of law enforcement, will take a look at the curious situation which exists with respect to the hundreds of chiropractors who, according to the outgoing Attorney General, are "guilty of the illegal practice of medicine."

Annual reregistration of regular physicians is supposed to insure the isolation and prosecution of alleged violators of the Medical Practice Act. It does not seem to be effectual in the case of chiropractors. What seems to be a special privilege will, we are sure, arouse the interest of the new Governor.

The Human Body—A Commonwealth

IN the democracy of the human body each cell is a citizen whose rights and dignities and sustenance are taken just as fully into account as those of whole organs. For the good of the body as a whole depends upon the functional integrity of each and all of its parts. "One for all and all for one" might be its motto.

So the body has been well called a cellular state and a commonwealth.

The organization of the body's specialized cells, while complex, is "marvellously regulated and coordinated," so that it reacts as an individual whole to external stimuli with all its activities correlated.

It would seem as though the human body might be taken by statesmen as a model "social unit in the natural economy." Its cells are well housed, well fed, and protected against injury; there is no bar to intercommunication with neighbors or the central government itself, i.e., the nervous system including the brain. Many ailments of man represent reactions and protests—revolution, if you like—against unreasonable physiological conditions imposed by the environment, reactions which always call into action the body's Office of Civilian Defense and its Healing Authority.

Loyalty and unity furnish the splendid working basis—for in this case the central government is not conducted by gangster-like politicians, commanding no confidence or respect, and there is no fifth column.

Perhaps we cannot hope for a social replica of the human body's efficient mechanism.

Nutrition and the Social Revolution

PROGRESS in fundamental nutritional research and the increasing application of new knowledge regarding dietetic requirements will be mighty factors in the forging of a new and healthier world. In England, all the people are subsisting upon better dietaries than before the war, with corresponding improvement in the health of mothers and infants; the national feeding is more uniform, with a leveling up of food consumption in the case of the less prosperous, and a leveling down of the food consumption of the well-to-do. Our American armies are being educated in food values, and many of their components will not be content with any return to the pre-war status in this respect.

Tea and Coffee Restriction

THE restriction, or deprivation, of tea and coffee will be one of the severest disciplines of the war, for the American people have depended much upon these stimulating agents. Drunk more or less in the guise of a social amenity, they have really been "indispensable" crutches. Much of our industrial effort has hinged upon them, and in those walks of life not calling for much stamina they have frequently buoyed up metabolism and spirit.

For commercial reasons and for reasons of creature comforts we have always blinked at the realities in the cases of things like tea, coffee, alcohol and aspirin. Yet who could reasonably assume that rather sudden deprivation of aspirin, for example, would be followed by no notable consequences—as though present dependence upon this drug carried no particular significance?

What will be the effect of reduced or interdicted consumption of tea and coffee upon the civil population? Will our neurotics be benefited or will they look for and find more harmful substitutes? Will fewer extrasystoles be encountered? Will emotional life be less keyed up and judgments more sober? Or will states of depression be more widely noted? Will fatigue states increase in frequency or will more restful sleep conduce to enhanced vitality?

It is not our understanding that the armed forces will share in this discipline; indeed, we gather that they are to be generously supplied with the stimulants in question.

These luxuries (necessities?) have formed an important part of the American's assortment of (softening?) comforts. Can the civilian function well without them?

To the normal, healthy, non-neuropathic human being the matter will not prove tragic; he can adjust to almost anything. But large segments of our population have been dubiously conditioned by the strains of our order of civilization. What phenomena will now be observed in them?

Sources of Character

VENEREAL disease is not a good in itself any more than is war. Both result from sickly social and economic conditions. Both enemies are infections. Both are palliated. But only in the case of war is rationalization attempted. Why not in the matter of venereal disease as well?

What is the nature of the fallacy that justifies the drafting of immature boys while it withholds approval of juvenile venereal infection?

If benefits to character accrue to extremely young men in the case of war—which is seriously affirmed by one school of psychiatrists—then comparable benefits should inure to very young men in the case of venereal disease.

The same school of psychiatrists that endorses potential participation in actual warfare in the case of relatively immature young men ought to endorse and advocate infection of such boys by venereal disease, for it could be claimed in the latter case, as least as plausibly as in the former, that certain desirable character traits are thereby developed—fortitude, patience, a medically inculcated flair thereafter for personal hygiene, and a broadened feeling for social realities and responsibilities, all of which, it is fair to say, tend to be engendered in one who has gone through the experience of venereal infection in the impressionable period of early youth.

The old laconism with which the victims of venereal infection used to be greeted—"You have now completed your citizenship," should appeal anew to the aforesaid school of psychiatrists.

For our own part, we believe that mere boys should be spared both dubious means of character development.

The Diagnosis and Treatment of IMPOTENCE IN THE MALE

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I HAVE purposely made the title of this paper "Diagnosis and Treatment" for the two are inseparable. There can be no rational treatment of impotence without accurate diagnosis. Briefly, for normal coitus there must be sexual desire or libido of the male for the female to start the series of events leading up to normal coitus. This must be followed by the influx of blood in the penis as well as the normal congestion of the prostate and prostatic urethra. It is necessary for the parts to be filled with blood for a normal time to maintain the erection of the penis. In order that the second event shall take place normally, it is necessary that the muscles surrounding the veins should remain in a state of tonic contraction for a normal period of time so that the blood which engorges the penis shall not pass out too soon with a consequent decline of the erection. As soon as the penis is to enter the female genitals, it is important that the latter should be in the proper position to receive the penis and properly lubricated to make the entrance smooth and easy. After the penis has entered the vagina, the various motions on the part of both parties must be so regulated that the ejaculation on the part of the male shall not be too rapid and shall continue, if possible, until the female has had her orgasm.

Such in brief are the series of events, and any disarrangement of any of these events may lead to impotence.

LET us now take up each item separately. I have said that there must be sexual desire of the male toward the female. This might seem obvious, but mistakes are often made in the diagnosis of this affair. Those who are not sexologists do not know how many cases of homosexuality appear in the doctor's office. If we do not think of the probability of such a condition, we will never make the proper diagnosis. Many cases of this sort are easy because the patient of his own accord frankly admits that he never cared for the opposite sex but only got married on account of the social and financial advantages to be gained. Some of these actually can have connection and bring forth children. But there are very many cases where the patient is not aware of such a state of affairs and merely knows that he cannot have an erection. A careful history will elicit the true facts and will show that this condition existed from the very commencement of his sexual life. Let no one think that the condition is psychological and requires psychic or psychoanalytical treatment. It is a definite endocrine condition and some of these cases are improved by endocrine treatment. I have always taken a very firm and definite stand in the consideration of these cases and will boldly state that there never was a case of true sexual inversion or of a true hermaphrodite that was cured by psychoanalysis. When we consider the truly wonderful experiments of Steinach and his coworkers in animals, we can readily understand why this should be so.

Steinach has shown in animals that by removing the testicles the animal will become sexually neutral and take no notice of the presence of females in heat. He then put ovaries into these neutral males and their entire sexual nature changed.

Their breasts swelled and at times even secreted milk. They adopted baby animals and treated them just as a normal female treats its young. In rats, even the squeal changed and became feminine in character.

On the other hand, he removed the ovaries from normal cows. Here again the animal became sex neutral and refused to permit the approach of the males. He then planted testicles in these neutral cows and they developed male characteristics, even jumping on female cows and attempting to have coitus with them.

BUT we need not limit our experience and conclusions to the above experiments on the lower animals. In human beings there have been found a sufficient number of sexual anomalies which distinctly bring out the influence of certain endocrine glands on sexual desire and development. There are a sufficient number of cases in which a person was brought up as a *girl* and attended a girl's school, but in whom, at puberty, *male* characteristics asserted themselves, and it was later found on operation that, with or without ovaries, there existed more or less developed testicles to account for the male characteristics.

In the female also the influence of the sexual glands has been more definitely noted. Years ago, when it was not at all unusual for a surgeon to remove both ovaries in a young woman, the most varied unpleasant symptoms due to a premature menopause asserted themselves. Today removal of both ovaries is avoided as much as possible; the gynecologist tries to preserve part of one or both ovaries, yet even here we find at times unpleasant symptoms coming on due to a premature menopause, or ovarian dysfunction from other causes, yet in many of these cases we can overcome these symptoms by the injection or even oral administration of certain hormones to supply the deficiency caused by the operation.

Can any impartial medical man, after the above experiments in animals and after taking into account the experiences in human beings, have the slightest doubt that libido and sex urge are, in the vast number of instances, due to endocrine influences and have very little to do with psychology. Magnus Hirschfield, perhaps the greatest sexologist of our time, made the statement that in all his vast experience he never saw a homosexual in which the condition was not due to endocrine influences and also he never saw one that was the least benefited by psychoanalytical treatments.

THE next event is the influx of blood into the penis by the arteries which gives it its erect and firm condition, accompanied at the same time by the contraction of the muscles surrounding the veins so that the blood shall not rush out of the penis as soon as it enters.

A disturbance of this mechanism is a very common cause (though not the only one) of either rapid or premature ejaculation. By rapid ejaculation is meant that the penis is able to enter the vagina, but after a few moments the erection declines, while in premature ejaculation the penis is unable to enter the vagina but the erection declines when it touches the external genitals of the female. Both rapid and premature ejaculation may be due to two distinctly different pathological conditions, which must be differentiated and which require different methods of treatment.

In one form the penis becomes erect but declines either before or after entrance into the vagina, without any ejaculation at all. In the other form the act is accompanied by ejaculation either before entrance or shortly after entrance. In those cases where there is no ejaculation, the condition is due to a weakness of the muscles surrounding the veins so that they cannot remain contracted long enough, with the result that the blood rushes out of the veins too soon with a rapid decline of the erection.

THOSE cases, however, which are accompanied by a too rapid or a premature ejaculation are generally due to a congestion or hypersensitiveness of the prostate and prostatic urethra which causes the reflex act of ejaculation to take place too soon. To explain the pathology in

these cases, I must again emphasize what I have done so often, namely, that there is nothing mysterious in the actions and reactions of the parts involved in the sexual act. There is no difference in the reactions of the nerves, blood vessels and muscles connected with the sexual act than those of nerves, blood vessels and muscles in any part of the body. A man with a normal nose may go out in any sort of weather without sneezing, whereas in a man with a congested nose, the reflex act of sneezing will take place with the slightest draft. The same reflex mechanism takes place with a congested eye or congested larynx. We therefore find the same physiology and pathology in the sexual apparatus. In a man with a congested verumontanum or prostatic urethra, the reflex act of ejaculation will take place at the very commencement of coitus due to the congestion of these parts.

I have gone at some length into a discussion of premature and rapid ejaculation because it is so important and one of the main reasons for unhappiness not only for the husband but also, and mainly, for the wife. During the precoital play and with the entrance of the penis into the vagina the erethism of the wife rapidly increases and she is in a state of nervous and expectant excitement which ought *normally* to end *after a time* in the climax of the female with the orgasm. When, therefore, while she is still in this state of excitement, the ejaculation in the male occurs, she is left in a state of nervous excitement, which, sooner or later, will lead to marked hysterical and nervous symptoms. As a matter of fact cases without ejaculation and where the erection subsides before the penis has been able to enter the vagina are not so bad, from the wife's point of view, because she has not been so thoroughly excited as in the other form. These are the cases that very often end in annulment or divorce. The patient himself very often appreciates the situation for many of them tell me that they come for treatment more for the wife's sake than for their own. We can thus appreciate the folly of the psychoanalysts who state that rapid ejaculation means that the man is dissatisfied with his sexual partner and wants to get through with the act as quickly as possible. As I have frequently stated in some of my previous articles, rapid ejaculation is not limited to married men but is also found in the unmarried. If, therefore, the view of the psychoanalyst is correct, then these unmarried men who visit houses of prostitution and have different sexual partners must be dissatisfied with all of them, and we wonder why they spend their money and run all the dangers of contracting venereal disease by coitus at all.

I HAVE stated that with the next event, the wife should be in the proper position to receive the penis. This may appear obvious and not worth mentioning. It is, however, not as obvious as one would imagine. There are several pathological conditions in the female which will prevent the entrance of the male organ. Among such may be mentioned dislocation of the hip joint, rheumatism or arthritis of the hip joint, curvature of the spine and similar conditions which will prevent the female from separating her thighs wide enough for the penis to enter. Less common are tumors of the vagina or about the genital organs. It is for this reason that I very often insist on examining the wife, as I have seen not a few cases where the man was treated with tonics, electricity, applications to the verumontanum and psychotherapy for months before it was discovered that the entire fault was with the wife. Many physicians never dream of such a possibility. As a hint in diagnosis it may be said that whenever a man tells you that he had always been normal before marriage and that he has strong and lasting erections but still cannot have connection, it is important to think of such a state of affairs and investigate accordingly. It is also for the same reason that I have, for years, advised the man specializing in orthopedic disorders that whenever a young girl is brought with some orthopedic deformity which may, in later years, interfere with coitus, to see if he can place the patient in the coital position, with-

out the child of course knowing the object, and if he cannot, to advise operation to correct the condition, even if no operation were necessary for the orthopedic condition for which the girl was brought to the surgeon. By so doing, the child will later on be spared much grief and tragedy and perhaps annulment of a marriage which might otherwise have been ideal. No matter what other excellent advantages a girl might have, no man would live with her if coitus was impossible.

It is true that in some of these conditions the obstacle may be overcome by the couple adjusting themselves and employing different positions for coitus. One cannot, however, tell beforehand whether the adjustment will succeed and, even when it is apparently successful, the husband later on gets disgusted with having to indulge in acrobatic features to enjoy coitus, and trouble ensues.

Among other conditions in the female which make coitus difficult or impossible may be mentioned vaginismus, dyspareunia and a rigid or sensitive hymen. These conditions are generally curable.

THERE is still another reason which makes coitus for the time being impossible. I refer to those cases where neither the husband nor the wife knew the proper position of the latter for coitus. I was the first to call attention to this state of affairs, and it is by no means rare. In these cases I asked the husband to lie down and place himself in the position the wife assumes during coitus. The man would lie down flat on his back, with his heels widely separated, but with no flexion at the knees or hips, that is, the knees were not drawn up toward the abdomen and everted. In the position the man showed me the wife assumed, it would be anatomically impossible for the penis to get anywhere near the vagina. This state of affairs may last for months or even years, without the patient or the physician ever thinking of the true reason for the impediment to coitus.

One sees from the above examples how important it is in many cases to interview the wife, and yet this is rarely done.

I have also mentioned that the wife's genitals should be sufficiently lubricated to make the entrance of the penis smooth and easy. In the majority of cases, the lubrication is normally supplied by the wife, as especially during the precoital play, the glands of the vagina pour out a large amount of secretion which is sufficient to lubricate the parts. At times, however, there is little or no secretion and it is necessary for the male to use some form of lubricant on his organ and perhaps for the wife to do likewise.

While normally the orgasm in the female comes somewhat later than the similar event in the male, there must, however, not be too much difference in the time of the events. For this reason it is advisable for the husband, if possible, to indulge in a sufficient amount of precoital play, so that, when he is about to insert the penis, the wife should already have reached a proper stage of excitement. All this, however, must be the result of previous experience on the part of the husband, otherwise the large amount of precoital play may tell on him and cause his ejaculation to occur too soon. If, however, the husband cannot adjust things properly, he should, for the sake of the wife, allow the penis to remain in the vagina even after ejaculation, making the usual movements till he appreciates his wife's orgasm. I may say here, that, contrary to popular belief, a small penis is rarely a cause of impotence. One cannot judge the penis when in the flaccid state but only when in the state of erection. It is not at all unusual for a small penis to enlarge very much during coitus In other words, I do not care how small the penis looks, if during connection it enlarges sufficiently to satisfy the man and his wife.

IN every case of impotence, one must think of such a condition as locomotor ataxia as well as other spinal or cerebral conditions, of diabetes and also of the possibility of homosexuality.

There is certainly such a condition as

psychic impotence just as we have psychic vomiting, psychic diarrhea, psychic frequency of urination, etc. Before, however, we make a positive diagnosis of psychic impotence we must thoroughly investigate whether there may not be a real organic basis for the impotence. Certainly no stomach specialist would neglect examination of the stomach and its contents in cases of vomiting simply because there is such a condition as psychic vomiting. In most cases of psychic impotence, the diagnosis is so simple that any physician with common sense can make the diagnosis, but the more intricate cases should be referred to a psychoanalyst. One must remember, however, that in every case of impotence there is a psychic element. In other words a person suffering from impotence worries more about his condition than if he were afflicted with some other condition. This, however, is not psychic impotence.

Treatment

AS stated so often, impotence, being dependent upon so many different pathological conditions, requires different methods of treatment. THERE IS NO SUCH THING AS A DRUG FOR IMPOTENCE.

I have said that the first incident in the course of events is sexual desire. In cases of homosexuality, we must try to change the sexual attitude by trying to supply the patient with additional male sex hormone. It has been shown that in every male there is in his blood a certain amount of male sex hormone, and also a much smaller amount of female sex hormone. As long as the ratio between the male and female sex hormones is of a certain standard definite relationship, that person is a normal male. But when the amount of male sex hormone is too little in proportion or the amount of female sex hormone is too large in proportion to the amount of male sex hormone, that individual is a homosexual. The attempt has been made to inject into the person some male sex hormone with the idea of bringing his ratio up to normal, and this has succeeded in a very small number of cases, too small for any real deductions. One reason for the failures is that in some of these cases there has been found on operation or autopsy that somewhere in the body the person had parts of, or even entire, ovaries which were continually pouring into his blood female sex hormones. Of course the presence of such abnormal findings cannot as a rule be diagnosed, unless for some reason or other an operation is performed. The important part of the entire discussion is to impress upon the reader that homosexuality is an endocrine condition and not a condition to be relieved by psychoanalysis.

BUT there are other conditions besides homosexuality which make for a lack of sexual desire. In many of these cases the wife should be interviewed in order that we may get her side of the story. It may be that a certain odor from perfumes used by the wife is obnoxious to the husband. Unclean habits of the wife as well as gross expressions during coitus make the entire act disgusting to the husband. Wives should be instructed that they should be as neat, trim and modest after marriage as they were before. Many a woman allows herself to become fat and ungainly with little care for her personal appearance and charms simply because she has acquired a husband. Modesty in a married woman is as essential as in the unmarried and is a great source of sexual attraction. The wife who forgets this and, simply because she is married, urges her husband in the most gross terms to cohabit with her when her passion is aroused, will in many cases cease to be a source of sexual attraction. There are very many delicate and modest ways in which the wife can indicate that she is willing and desirous of having connection, and which would be a real stimulus to her husband's passion. On the other side, we cannot always take the wife's diagnosis that the husband has lost all sexual desire, for I have seen very many cases in which the wife complained to me about this and, upon tactfully interviewing the husband, it was found out that he did not at all

lose sexual desire, but that his desire was directed more toward his secretary than to his wife.

IN those cases where the principal symptom is a premature or rapid ejaculation, examination will show, as already indicated, that the condition is due to a hypercongestion of the prostate and prostatic urethra. We find a large, boggy, soft prostate on rectal examination, and the cysto-urethroscope will show a marked congestion of the prostatic urethra, especially in the region of the verumontanum. In explaining this state of affairs to the patient, it is very important to have him understand that the condition is entirely different from the hard senile prostate found in elderly people. Unless this is made perfectly clear to the patient, he is liable to confuse the two.

The treatment of this condition is very simple and very important. It is absolutely essential to get rid of the congestions first before starting any stimulating treatment. Many physicians, when confronted with a case of impotence, no matter from what cause, immediately give stimulating treatment either by electricity or the latest and most advertised sex hormone. The treatment is like whipping a tired horse; it might make him go quicker for a short time, but in the end he is worse off than before. We must always keep in mind that the object of treatment is not to cause a temporary improvement in the condition, but to make the patient permanently well. Here, again, we must fall back on the analogy between the sex organs and other functions of the body. Would a throat specialist when confronted with a patient who is hoarse due to overuse or abuse of the voice advise the patient to talk a great deal on the plea of strengthening his vocal cords? He certainly would not, but would apply some silver nitrate solution or one of its modern substitutes or some other remedy to his vocal cords to relieve the congestion. And this is exactly what should be done to our impotent patient.

THE object treatment is therefore to remove the congestion of the parts. For this purpose the patient should receive, about every five days, *gentle* massage of the prostate and at the same time an instillation of *weak* silver nitrate solution to his prostatic urethra with the Bangs' sound syringe. I emphasize "gentle" because the object is to improve the circulation in the prostate and not to try to squeeze out every drop of prostatic secretion as is sometimes done in cases of chronic gonorrhea on the theory of ridding the prostate of gonococci. Massage of the prostate is massage just as in any other organ; giving a man a punch in the stomach is not massage of the abdomen. Massage of the prostate is really an art that it takes much experience to acquire. It is best given with a full bladder as this will push the prostate toward the finger in the rectum. I have also emphasized the importance of *weak* solutions of silver nitrate. We are not looking for the antiseptic or caustic properties of silver nitrate, but for its tonic effect. I start with a 1:3000 solution and gradually increase till a 1:500 is reached. These treatments should be given about every five days.

It is important that the patient should avoid during these treatments tea, coffee, and alcoholics. It is important always that he lead a normal sexual life and refrain from all unnatural or ungratified sexual practices such as withdrawal, spooning, etc.

THERE are many patients who, after the local congestions have been removed, have been restored to normal sexual vigor. If, however, the condition has lasted a long time, the muscles and nerves connected with the sexual act have become weakened and stimulation is necessary. Such stimulation, however, must never be given till the local congestions have been removed. The stimulating treatment is exactly the same as that presently to be described for weakened sexual muscles.

In those cases where there is either no erection or a very feeble erection with rapid decline but without ejaculation, the condition is due either to weakened sexual muscles or to weakness of the muscles

surrounding the veins as previously described. The treatment is about the same in both cases. It is distinctly stimulating in character.

In the treatment I employ the sinusoidal-faradic current of moderate rapidity and as strong as the patient can stand without any pain. One cable is connected with a rectal electrode and the other with a wet sponge electrode applied to the perineum and the current is allowed to pass for about ten minutes. Treatments may be given two or three times a week. There is not the slightest doubt that this treatment stimulates and develops the muscles of erection. The advantage of sinusoidal-faradic current over the plain faradic current is that there is not a single cramp as with the latter but a series of contractions which does the work. In the sinusoidal-faradic current the pole changes with every revolution, so that it is immaterial which cable is connected with which pole.

IN addition to the above treatment I very often give testosterone propionate, prepared synthetically from cholesterol. Although not a testicular extract it is of especial value where it is believed that the testicles do not throw enough hormone into the blood. There is practically no way of proving this condition, but clinically, it greatly helps in the treatment of impotence. I have gotten my best results from large doses, 25 to 50 mg. two or three times a week. Besides improving the impotence, the patients generally put on weight and have a general feeling of well-being. In its field it is one of the most remarkable and successful drugs in impotence. I have already reported in my book and medical articles several notable successes, especially in cases of long-standing impotence, but cannot help reporting a most remarkable experience. This was in an old man of about 70, who came to me for an enlarged senile prostate. He was definitely opposed to operation and wanted me to try something for his condition. He had a distinctly enlarged senile prostate. His wife was an invalid and for many years he did not have any connection and indeed was not at all interested in coitus.

With an idea of reducing the size of the prostate, I gave him three times a week an intramuscular injection of 50 mg. of testosterone propionate. After a few weeks his prostate was smaller but he told me that he would have to give up the treatments because every morning he got very large, firm and lasting erections.

There is but one caution in the administration of testosterone propionate, and that is, for the time being, there is a distinct diminution in the number of spermatozoa in a semen specimen and finally they are absent altogether. If the question of sterility comes up, this must be remembered. This effect, however, is only temporary, the spermatozoa coming back as soon as the administration is stopped. I mention this because I have read of even experienced physicians who actually gave this preparation in the hope of curing their sterile patients. Aside from this effect there is no contraindication to giving testosterone propionate.

IN those cases in which the impotence is due to the weakness of the muscles surrounding the veins, and which have not been improved by the above treatment, the only procedure left is the tying of the dorsal vein of the penis. This is a very simple operation, but one must be certain to actually tie off the principal vein and not one of the small superficial veins which appear at the operation. One can make a guess at the prognosis by the size of the vein; a large well developed vein gives a better prognosis. The results of this operation are at times good. This operation must not be confused with the more formidable operation devised by Lowsley. I have had no personal experience with this operation but Dr. Lowsley reports good results from it at times.

88 CENTRAL PARK WEST.

Non-Occupational
NICKEL DERMATITIS

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TWO cases of nickel dermatitis observed during recent months, which showed certain peculiarities, are reported in this paper.

Case 1

Mrs. K.W.; in her menopause since September 1941; well nourished; her digestion is normal.

History

Eighteen years ago the patient had an inflammation of her face, which lasted about two years and finally responded to irradiation. Since then, she had no skin eruptions. She had attacks from gallstones four and two years ago.

More than three months before the present disease broke out a slight irritation appeared on both thighs confined to the region which is continually touched by the fasteners of the garters. One month later the cubital folds and, another month later, the face became involved. About two weeks later, a physician was consulted. The condition was treated with a liquor alumini salve (about 1.5%) during the daytime, nupercainal during the night, and a powder in addition to some light treatment. After an initial improvement, the condition grew worse and was not prevented from further spreading. No suspicion was aroused against the garters and the patient continued to wear them.

Present Condition

Severe redness, swelling, and—at certain points—oozing of the skin of both thighs, arms, face, neck and chest. The face is strongly edematous, including especially the eyelids; there the swelling is so severe that the eyes can hardly be opened. At some places the skin eruption has an urticarial character.

Laboratory tests: Hemoglobin 92%, leukocytes 9,500, neutrophiles 71%, lymphocytes 18%, eosinophiles 1%, basophiles 1%. Urine: specific gravity 1.011, albumin 0, saccharum 0. Wassermann, Kahn negative. Patch tests with 10, 5 and 2% aqueous nickel sulfate solution strongly positive (see below).

Diagnosis

Acute urticarial eczema, most probably due to a sensitivity to nickel.

The treatment in addition to the elimination of the nickel fasteners of the garters consisted of prolonged hot washings with chamomile tea followed by the application of zinc oil with 2% liquor plumbi and of lukewarm compresses with chamomile tea applied to the eye regions.

Improvement was definite after 48 hours. The treatment was ordered to be continued and a patch test was made with a 10% nickel sulfate solution. When this was removed after 48 hours the reaction was positive: redness and swelling. This reaction increased strongly, forming a vesicular, oozing, crusty, cushion-like patch during the next three days. At the same time improvement (including that of the face condition) ceased; the face seemed again more inflamed than after the first two days of treatment. Administration of a tannic acid-zinc-bismuth cream and a liquor aluminii cream respectively in addition to the hot washings brought about another period of improvement.

New patch tests were made (12 days after the previous ones) with nickel sulfate solution 2, 5 and 10% applied to apparently "normal" skin of the arms and thighs respectively. All of them were strongly positive after 48 hours in con-

From the Dermatologic Section of the Grace Clinic.

trast to two normal test individuals who responded negatively to the same concentrations and two other persons who responded negatively after being tested with a 10% solution. The patient herself showed a flare-up of all the areas previously involved. The eruption finally disappeared under the use of liquor alumini cream, zinc-ichthyol cream, and zinc lotion, the latter applied to the thighs. The patient was last seen on March 31st, i.e., 21 days after the first consultation.

Patch tests intended with nupercainal could not be made because the patient did not return for further tests, probably because she was afraid of another possible flare-up such as was encountered after the former nickel patch tests. However, the fact that the flare-ups during the patch-testing period involved all the formerly inflamed places points more in favor of the nickel as the casual factor, although additional reactivity cannot be excluded completely because of the lack of the nupercainal patch tests.

Liquor alumini acetatis proved to agree with the patient.

Case 2

Mrs. Ch. K. is 49 years of age and in menopause for 6 months.

History

For many years (beginning 1927) vesiculopustular eruptions appeared in rather sharply bordered areas of both thighs (anterior and posterior surfaces) and on the dorsa of the hands including fingers. A vesicular eruption and interdigital eczema were also present on the feet where fungi had been found by a very reliable dermatologist some time ago. The condition had always been treated with the diagnosis dermatophytosis and sensitivity to rubber (garters); patch tests had not proved the casual relationship of the latter; but the rubber parts of the garters, and with them—automatically—the nickel fasteners, had been temporarily separated from the skin by interposition of layers of some fabric. Intervals in which the patient had had some respite were never longer than about nine months. The condition used to improve during winter; however, it did not disappear completely during that time of the year either.

Present Condition

At the first consultation reddish, scaling patches were present on the dorsa of the hands, with vesicles on the fingers and on the toes including the interdigital spaces of both feet. The skin of the face was swollen with a more pronounced edema in the eye and chin regions. Urticarial patches were present on the chest, the trunk including the abdomen, the gluteal regions and the thighs. Some of the patches and some other areas, which, according to the history given by the patient, had been urticarial before, showed dark, red, violet, and brown-green-yellowish (hemorrhagic) discolorations. A palm-sized area on each side of the waist region was red, vesicular, and scaling. On the anterior and posterior surfaces of both thighs similar but larger patches were present.

I COULD not find any fungi in the eruptions of the hands and feet at the first consultation.

A remarkable improvement took place during the first four weeks of external treatment with various pastes and salves; then a severe relapse occurred with a grouped papulovesicular eruption, especially on the right forearm. This gave rise to further examinations; a differential count of the blood revealed 6% eosinophilic cells. A patch test made with 25% potassium iodide vaseline resulted in a strong reaction within 24 hours. An oral arsenic treatment was instituted in addition to an indifferent external treatment. The condition improved during the next few weeks, the itching disappearing completely except in the patches on the thighs. There was no urticarial eruption nor any hemorrhagic manifestation thereafter.

A retention of fluid was occasionally accompanied by a slight papulovescular eruption on the fingers and toes (fungi repeatedly could not be found). This disappeared quickly when the urine elimination was increased.

The stubbornness of the patches located on the thighs after six weeks of arsenic treatment (in contrast to the rapid response of the other manifestations) induced the application of patch tests with 10% nickel sulfate to the "normal" skin of the patient: the reaction was positive: red, vesicular, cushion-like. Patient did not react to 5% ammoniated mercury vaseline. The nickel fasteners of the garters were replaced by non-metallic locks with the result that the dermatitis disappeared, although the arsenic treatment had been discontinued after one more week (a total of 7 weeks) because of neuritic pains (Feb., 1942). Except for a few occasional papules at one time, the thighs remained normal even at the time when the vesiculopapular (hands) or eczematous manifestations (waist line) appeared.

This complicated case showed, in addition to a dermatophytosis, eruptions which could be finally diagnosed as a dermatitis herpetiformis and a sensitivity to nickel. The manifestations became more outspoken at times when the patient had an apparent retention of fluid. How far the nickel sensitivity is autonomous or related to the dermatitis herpetiformis and the sensitivity to potassium iodide and the retention of fluid cannot be determined yet. Further investigations in cases of Duhring's disease and of nickel sensitivity will be necessary.

Summary and Conclusions

TWO cases of nickel sensitivity have been reported. Both cases have in common that the dermatitis originated in the region where the fasteners of the garters were in continuous contact with the skin for many years. Both patients are women in the climacterium. In the first case the dermatitis appeared soon after establishment of the menopause; in the second it had been present for many years before the menopause. Both gave positive tests (patch) in respect to their "normal" skin in contrast to negative results in control individuals. Patient No. 1 showed flare-ups as focal reactions during the patch test period; this was the reason why the patient did not appear for further patch tests intended to be made with nupercainal. Patient No. 2 was complicated by a dermatitis herpetiformis with a tendency to retain fluid and by a dermatophytosis. Whether the repeated eruptions on the fingers in the second case were due to the dermatitis herpetiformis or to the dermatophytosis (dermophytide?) or to occasional contacts with nickel plated household implements cannot be determined. Both cases (the second as far as her nickel sensitivity was concerned) responded to indifferent treatment.

Nickel sensitivity as in the case of any other sensitivity can develop in people who could handle nickel and wear nickel-containing apparel before, for many years, without having trouble. The eventual development of a nickel sensitivity may be encouraged by other factors, constitutional as well as external; they may be represented in our cases by the climacterium (changes in the neutralizing power and acidity of the skin) or by the dermatitis herpetiformis or the dermatophytosis, which—permanently or temporarily—may make the skin more susceptible for any sensitization. The reaction may not remain restricted to the area of contact but may spread.

Repetition of the contacts may result in accelerated local and focal reactions.

Cure will be accomplished under indifferent treatment after the elimination of intimate and prolonged contacts with nickel.

The daily temporary contacts of short duration with nickel plated materials such as handles, scissors, spoons, etc., usually do not seem to be sufficient to provoke or maintain a dermatitis or to provoke a recurrence in people sensitized to nickel. However, such contacts must be taken into consideration as the possible causes of prolonged or recurrent dermatitis in exceptionally sensitive individuals.

121 FORT GREENE PLACE.

SQUAMOUS CELL CARCINOMA OF THE GALLBLADDER

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PREPARATORY to the presentation of a case of primary carcinoma of the gallbladder, it would seem advisable to briefly review some of the recent literature on the subject. In the most comprehensive survey attempted by Conrad R. Lam in 1936, (1) it was estimated that some 6,500 persons in the United States died of primary carcinoma of the gallbladder, and this is about 4.5 per cent of the total malignancy deaths.

Incidence

SURGICAL experience has shown that carcinoma in one of its various manifestations is found in from 1 per cent to 2.5 per cent of all gallbladder operations. Furthermore, though records show carcinoma occurring at all ages from 22 to 95, the great majority fall into age groups from 50 to 65 years, and the disease is distinctly rare before the age of 40 (2). It predominates in females with the accepted ratio of 3.1. As yet no racial predilection has been published.

Classification

CARCINOMA of the viscus manifests itself in one of four varieties: (1) Scirrhous carcinoma; (2) Papillary carcinoma; (3) Colloid or mucoid carcinoma; (4) Squamous cell carcinoma. The last, with which this paper is primarily interested, is the least common.

Etiology

THERE are two recognized etiological factors for squamous cell carcinoma: (1) embryonic rests; (2) Cholelithiasis. A satisfactory explanation as to how the alleged presence of embryonic cell rests (Cohnheim) operates has not been generally accepted.

Cholelithiasis results in chronic inflammation and irritation of the mucosa of the gallbladder. Calculi, especially with the presence of roughened surfaces, undoubtedly produce constant irritation which leads to atypical transformation of the cells of this mucosa. Musser found that 69 per cent of gallbladder malignancies contained stones. Futterer reported 70 per cent; Zenker 85 per cent; Deaver 89 per cent; Judd and Baumgartner 94 per cent and Janowski 100 per cent. In some reported cases the presence of stones was not mentioned. However, none of the reports stress the absence of stones. (3) The origin of this squamous type of epithelium occurring in mucosa which is normally columnar, has been suggested by Roessiger. (4) He bases his explanation on Krompecher's theory (5) that the basal cell, which is represented by a layer in the mucosa of the gallbladder, is multipotent and is, therefore, capable of developing into either cylindrical or flat epithelium, depending on the type of stimulation. The calculi being an adequate stimulus results in the formation of the atypical squamous cells—epithelioma.

Symptomology

ANOREXIA, nausea, right hypochondriac pain or referred pain in the epigastric region, the presence of a nontender tumor in the right upper quadrant, the absence of acute inflammation indicated by no rise of temperature or leucocytosis, plus weight loss in a person within the fifth and sixth decades, should strongly suggest the presence of gallbladder ma-

lignancy. Jaundice will be present when the common bile duct is obstructed. Theoretically this should occur only when the disease is far advanced.

Summary

1. Primary carcinoma of the gallbladder is rare but not uncommon, and of the types above enumerated squamous cell epithelioma is the least common.

2. It is generally accepted that cholelithiasis, which produces chronic irritation, is also the etiological factor that causes the formation of squamous cell carcinoma of the gallbladder.

3. For the prevention of gallbladder malignancy the early removal of the gallbladder containing calculi is advocated.

Case Report—H. D.

History: 1st admission, West Medical. Patient was a 63-year-old, white, single female whose first hospital admission (on Medical Service) was in November, 1940, at which time a diagnosis of acute cholecystitis was made. This attack subsided under medical treatment and patient was discharged on 9th hospital day. Flat abdominal plates taken at that time revealed no evidence of gallstones. Diagnosis of psychosis also made on this admission based on paranoid delusions.

2nd admission, East Surgical. Patient was admitted to Surgical Service August 18, 1941 with history of frequent attacks R.U.Q. pain, belching, vomiting daily, anorexia, weight loss, obstipation and ability to take only liquid nourishment. She stated she felt fairly well since her discharge in November, 1940 until February 1941, i.e., about six months previous to admission. All symptoms except R.U.Q. pain have been progressive and more marked during several weeks prior to admission. Had no jaundice. Patient expressed paranoid ideas at time of admission and would express such ideas in describing her illness, although unrelated.

Family History Father died of "jaundice," of doubtful etiology. Brother died at 51 years of age of CA of esophagus.

Physical Examination Revealed an elderly, fairly well developed and poorly nourished white female showing obvious weight loss and pallor but in no acute distress. No icterus.

Examination of abdomen revealed a firm, slightly tender mass filling the R.U.Q. below the costal margin which was felt to be an enlarged liver, the edge of which could not be felt because of tenderness. Below the mass there was a large ovoid tumor of firmer consistency over the course of the ascending colon. No spasm or rigidity present.

Heart Except for slightly enlarged left heart border and P. 156/84, the remainder of the P.E. was essentially negative.

Laboratory studies Admission r.b.c. 4,145,000 (dehydration a possible factor)
w.b.c. 7,300
Hb. 75%

Smear—normal differential count.

Urine Negative on admission but later showed slight trace of alb. and granular and hyaline casts.

B. S. 89 mgm. %; N.P.N. 39 mgm. %.

I. I. 6.6.

Barium enema (Aug. 19, 1941). No pathology.

G. I. Series Aug. 22, 1941
Revealed stomach enormously distended and no barium had left stomach in 4 hours and only small amount in 24 hours. There was also a pressure defect (extrinsic) at the pyloric region of the stomach.

Gastric lavages were carried out to remove barium retained in stomach and on Aug. 25, 1941, i.e., 3 days following G. I. series, a Graham test was done.

1st Graham Test (Aug. 25, 1941) Unsuccessful due to retained barium in stomach and intravenous administration of dye advised.

2nd Graham Test (I.V. method)
Revealed no definite gallbladder shadow. Conclusion—complete loss of gallbladder function.

Course in hospital Patient continued to vomit even liquids, became gradually weaker, was sustained with intravenous fluids and transfusions and continually refused operation. With supportive treatment she improved slightly to a point at which it was felt she might possibly withstand surgery. She finally consented to submit to surgery at this time and on her 23rd hospital day a cholecystectomy with drainage was performed.

Description of Operation and Findings I. Operation. 9/10/41

Anesthetic—gas-oxygen ether. Montreal method.
A. Description.
Usual gallbladder incision was used to open the peritoneum. A large dense mass of adhesions was found adhering the dome of the gallbladder to the parietal peritoneum. This was freed by blunt dissection. The gallbladder appeared to be a glistening white organ, markedly distended with impacted calculi. It was now freed from the pylorus (of the stomach), to which it was firmly adherent; but the maneuver still left a marked deformity in the lowest segment of the stomach. The gallbladder was opened and innumerable stones were evacuated. This organ was then freed from the adjacent liver and removed from above downwardly. The cystic duct was completely obliterated as was the cystic artery. There was slight oozing from the peritoneal surface of the pylorus, which was controlled by hot tamponades. Two Penrose drains were then placed in the gallbladder bed and the layers of the abdominal wall closed about them.

II. Post-operative diagnosis Cholecystitis with stones and malignancy.

Pathology Squamous cell carcinoma (high malignancy); Cholelithiasis.

Postoperative course Patient responded fairly well during early postoperative course but continued to vomit and later was unable to retain anything by mouth. Wound edges became separated and incision became infected as result of constant daily vomiting. Parenteral fluids were given daily but the course was a progressively downhill one. She became comatose and expired on 31st postoperative day. Developed terminal bronchopneumonia in latter part of illness.

WORCESTER CITY HOSPITAL AUTOPSY REPORT

Name, H. D. **Autopsy No. A171-41.** **Age, 63** **Sex, FEMALE.**
Color, WHITE. **Hospital No. 295917** **Date of Death, OCTOBER 21, 1941**
Hour, 11:25 A.M. **Date of Autopsy, OCTOBER 21, 1941** **Hour, 1:15 P.M.**
Autopsy by, JAMES P. MULLOWNEY, M.D.

BRIEF CLINICAL HISTORY: Patient was admitted on 8-18-'41 with complaint of vomiting, constipation and pain in right lower quadrant of 6 months duration. She had been in WCH in November of 1940 for the same complaints; was discharged with diagnosis of cholelithiasis. Symptoms began to recur in February, 1941. She had gradually become worse.

P. E. EENT negative. Lungs clear P and A. Heart was slightly enlarged to left, rate and rhythm regular. No murmurs. Abdomen—there was described a firm, slightly tender mass filling the RUQ and extending downward along the course of the ascending colon. No spasm of viscera or other masses noted.

Lab. findings: urine showed trace of albumin and occasional white cell. Blood count decreased from 4,450,000, WBC 7,300, 75% hgb. on 8-19-'41 to 3,200,000 reds, 11,300 whites, 64% hgb. on 10-5-'41. K and W negative. Sugar 89 mgs. NPN 39 mgs. Icteric index 6.6. Feces constantly showed occult blood. Fluoroscopy showed a distended stomach with greatly prolonged emptying time. The conclusion reached was that there was an obstructing lesion in pyloric region extrinsic to the pylorus.

Progress: On 9-10-'41 under GOE a cholecystectomy was done with removal of a large gallbladder with white, thickened walls and many palpable small stones; many dense adhesions were noted in this region. Pathological report of the specimen showed a squamous cell carcinoma of gallbladder. Following operation patient's condition showed moderate temporary improvement. Then the vomiting began again, wound continued to drain large amount of purulent material, and the patient's course was gradually downhill. She expired on 10-21-'41, the 65th hospital day. CLINICAL DIAGNOSIS: Squamous cell carcinoma of gallbladder; cholelithiasis.

Anatomical Diagnosis

Squamous cell carcinoma of gallbladder with local invasion of liver and stomach at pylorous producing obstruction.
Pulmonary edema.
Bronchopneumonia.
Early generalized arteriosclerosis.

The body is that of an emaciated, white female 65 inches (157.5 cm.) tall and weighing 75 lbs. (34 kilogms.) Inguinal and left supraclavicular glands are enlarged and hard. There is beginning rigor mortis; there is no lividity. There is no edema. The breasts are negative. There is one plus clubbing of the fingers. The pupils measure 7 mm. in diameter, each. The teeth are artificial. Skin and sclerae show a slight icterus. There is an upper right rectus, almost midline, incision 10 cm. in length, middle part of which gapes widely. Peritoneum is closed but as far as can be determined there is no approximation of the fascia.

Head: Not opened.

Thyroid: Normal in size, color and consistency.

Thorax

Pericardial cavity: 8 cc. of clear straw-colored fluid present.

Heart: Weight 180 gms. Ventricles are moderately firm, somewhat pale brown in color, and on section show greyish streaking presumably due to myocardial fibrosis. Aortic valve shows slight sclerosis and thickening. Mitral valve shows a moderate to marked beading of the free edge throughout its entirety. The appearance is suggestive of old, healed vegetations. Tricuspid and pulmonic valves are negative. Coronaries show moderate sclerosis. Measurements: tricuspid valve 10.3 cm., pulmonic valve 6.2 cm., mitral valve 8.5 cm., aortic valve 7.7 cm., left ventricle 1.4 cm., right ventricle 0.3 cm.

Pleural cavities: Are completely obliterated by dense adhesions.

Lungs: Weight of left 420 gms., right 430 gms. The upper lobes of both lungs are pink in color, lower lobes are dark red. Spots of frank pus can be expressed from both lower lobes. Both lungs are moderately edematous throughout.

Mediastinum: Contains a few anthracotic glands.

Abdomen

Peritoneal cavity: There are a few adhesions in the right upper quadrant around the region of the abdominal incision.

Spleen: Weight 60 gms. Surface is bluish-grey in color and somewhat wrinkled. Pulp is dark red in color, firm, and the markings are distinct.

Gastro-intestinal tract: Esophagus is negative. The mucosa of the stomach is normal in apperance but there is very definite obstruction produced at the pylorus by an extrinsic mass. A forceps can be passed through the pyloric opening. The mucosa is negative but grossly there appears to be invasion of the outer coats by the squamous cell carcinoma originating in the gallbladder. Small bowel and large bowel are grossly negative.

Liver: Weight 1620 gms. The lower edge is rounded. Color is yellowish-brown, very suggestive of chronic passive congestion. Bile escapes freely from the bile ducts showing on the cut surface. The liver is irregularly invaded to a depth of 5-7 cm. by a hard, whitish homogeneous mass, apparently metastasizing squamous cell carcinoma by direct extension from the gallbladder.

Gallbladder: Has been removed at operation. There is found in its place a very hard greyish-white mass involving the neighboring liver, the pylorus, first portion of duodenum and the head of the pancreas, and in which the hepatic and common ducts are inextricably bound; running as they do to the center of this mass the common bile duct and pylorus are subject to great extrinsic pressure, which is responsible for the obstruction found in each.

Pancreas: The head of the pancreas is caught into the carcinomatous mass previously described. On section tissue of the body and tail appears grossly normal. Central duct is somewhat dilated.

Adrenals: Show moderate medullary cavitation.

Kidneys: Weight of left 110 gms., right 90 gms. Capsules strip easily, leaving finely granular surfaces. On section the color is dark red, suggesting chronic passive congestion. The markings are completely obscured. Calices and pelves are normal in appearance.

Ureters: Negative.

Bladder: Negative.

Genitalia: Tubes are negative. Uterus and ovaries are atrophic.

Blood vessels: Aorta shows an early process of sclerosis.

Microscopic findings: Thyroid—negative; Lung—bronchopneumonia; Spleen—chronic passive congestion; Liver—metastatic carcinoma; fatty infiltration; acute hepatitis; Pancreas—negative; Adrenals—negative; Kidneys—nephrosclerosis; hydronephrosis, slight; Bladder—negative; Uterus—slight fibrosis; Ovary—negative; Gland—chronic lymphadenitis.

WORCESTER CITY HOSPITAL PATHOLOGICAL LABORATORY

Name, H. D. Service, E. S. Ward, M Date, SEPT. 10, 1941 Serial Number, S1973-41. Age, 63. Specimen, LYMPH NODE FROM PERITONEUM: GALLBLADDER: STONES.

GROSS: Specimen consists of a piece of tissue measuring 0.7x0.5x0.3 cm. On section it is partially calcified and yellow in color.

A gallbladder measuring 7x4x2.8 cm. Wall varies from 0.3 to 1.2 cm. in thickness. The mucosa is roughened, yellow and has calcified plaques. Portions of the wall are greatly thickened, irregular, yellow and hard. There are several dozen stones, facetted, white in color and varying from 0.3 to 1.5 cm. in diameter.

MICROSCOPIC: Section of the gallbladder wall shows both glands and solid islands of epithelial cells in a rich connective tissue stroma. The glands are invading the wall. The nuclei of these gland cells show variation in size and shape, and loss of polarity. The solid islands of cells have undergone metaplasia to the squamous cell type as evidenced by the presence of epithelial pearls. Here the nuclei also show variation in size, shape and staining quality. A few mitoses are present. In some glands a small segment has developed squamous epithelium while the rest of the cells complete the gland structure. Part of the wall is hyalinized.

DIAGNOSIS: Squamous cell epithelioma of the gallbladder (high malignancy). ... .
Cholelithiasis.

R. H. Goodale, M.D.

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Presidency of Long Island College of Medicine

The trustees and faculty have the honor to announce the installation of Jean Alonzo Curran as president of Long Island College of Medicine at Polhemus Memorial Clinic, Brooklyn, New York, Thursday, the nineteenth of November, one thousand, nine hundred and forty-two at four o'clock.

III
CANCER OF THE BREAST

Classification—Varieties—Complications

Classification

IN a paper based on a study of cases in St. Bartholomew's Hospital (London) and in the Royal Cancer Hospital (Free) (London), Raven (21) pointed out that there is no uniform classification of cases of carcinoma of the breast. He said that if there were a uniform method, much useful information could be obtained bearing upon the questions of progress, of the relative value of the various therapeutic measures employed, and greater uniformity in the publication of the results of treatment.

He proposed the following Classification:

1. The assessment of the stage of the disease in the breast.

Stage I. Definition: The carcinoma is strictly confined to the breast.

Stage II. Definition: The carcinoma infiltrates the skin (Stage II. skin). The carcinoma infiltrates the pectoralis fascia (Stage II. fascia).

Stage III. Definition: The carcinoma infiltrates the pectoralis muscle (Stage III. muscle). The carcinoma ulcerates through the skin (Stage III. ulcer).

Stage IV. Definition: The carcinoma infiltrates the ribs, the costal cartilages or the sternum (Stage IV. bone). The carcinoma infiltrates the whole breast with *peau d' orange* and/or infiltration of the underlying pectoralis fascia and muscle. (Stage IV. whole breast).

2. The assessment of the stage of the disease in the regional lymphnodes and perinodal connective tissues.

Stage a. Definition: The carcinoma involves the lymphnodes under the lower border of the pectoralis major muscle.

Stage b. Definition: The carcinoma involves the lymphnodes under the tendon of insertion of the pectoralis major muscle.

Stage c. Definition: The carcinoma involves the lymphnodes under the tendon of the pectoralis minor muscle.

Stage d. Definition: The carcinoma involves the supraclavicular lymphnodes.

Stage e. Definition: The carcinoma involves the mediastinal lymphnodes.

IF THE carcinoma has spread into the perinodal connective tissue, the symbol ′ is placed opposite the appropriate group of lymphnodes affected in this way—a′, d′, etc.

For example: A carcinoma of the breast which infiltrates the pectoralis major muscle. There are metastases in the lymphnodes under the lower border of the pectoralis major muscle and the carcinoma has spread to the perinodal connective tissue. (classification III (Muscle) a ′).

A case in which the carcinoma infiltrates the whole breast, with *peau d' orange* and infiltration of the pectoralis major muscle. The lymphnodes under the lower border of the pectoralis major muscle and the lymphnodes under the tendon of the pectoralis minor muscle are involved. There are metastases in the lungs (classification IV (whole breast) a, c, lu).

Portmann (20) advocates the method of classification of cases of breast cancer suggested by Steinthal (*Beit. z. klin. Chirur.*, 1905. 47:226): Group I, cases in which there are slowly growing tumors, measuring only a few centimeters in diameter, entirely confined to the mammary gland, the skin not adherent and the axillary lymphnodes not involved as proved by histological study.

Group II cases in which there are definitely growing tumors, with metastasis to the axillary lymphnodes, which might not be determined clinically, but which show definitely on histological study.

Group III cases in which there is extensive growth in the breast with extension to the skin and the underlying tissues and with metastases to the supraclavicular as well as to the axillary lymphnodes.

There seems to be no uniform method of classification of breast cancer. In assessing the relative value of treatment with surgery, with irradiation, and with surgery and irradiation, it would appear that an agreement on this point would be advantageous.

The Steinthal classification is also used by Uhlmann (27), who has reported sixty cases from the University of Istanbul (Turkey).

It seems to us that, although the classification suggested by Raven (21) at first looks rather complicated, it is the best classification yet suggested for the appraisal of the relative value of the different forms of treatment.

Varieties

THE classification of breast tumors and the varieties of breast cancer are fairly closely associated. In the third edition of his work on Neoplastic Diseases, Ewing (6a) records the following varieties of breast cancer: Adenocarcinoma, arising chiefly in cysts or ducts and sweat glands; duct carcinoma, arising from the lining cells of ducts; acinar carcinoma, arising from the epithelium of the acini. "Of these groups there are several subdivisions, such as gelatinous or mucous carcinoma, fibrocarcinoma, and carcinosarcoma."

In 1935 he said (6b) that the chief source of confusion in the nomenclature of mammary cancer lies in the tendency to employ histologic terms such as medullary carcinoma, scirrhus carcinoma, fibrocarcinoma, cancer *en cuirasse* and carcinoma simplex instead of well defined anatomical and clinical types. None of these histological terms should be employed as the primary entry for any clinical or anatomical variety of mammary carcinoma. He suggests the following classification: (1) Adenocarcinoma arising in cysts. (2) Mucous or gelatinous carcinoma. (3) Duct carcinoma: (a) Localized, (b) Diffuse. (4) Paget's Disease. (5) Carcinoma arising in Chronic mastitis. (6) Sweat Gland cancer. (7) Inflammatory carcinoma.

In 1940 (6c) he recognized the following clinical varieties of carcinoma: (1) Adenocarcinoma; (2) meduliary or encephaloid carcinoma; (3) acute carcinosis; (4) scirrhus carcinoma; (5) fibrocarcinoma; (6) mucoid carcinoma, and the following varieties of sarcoma: (1) round cell sarcoma; (2) pure spindle cell sarcoma; (3) adenosarcoma; and (4) melanoma.

These growths are all malignant. They metastasize and unless completely destroyed will end the life of the patient.

From the point of view of recording survivals of breast cancer, after different forms of treatment, Meland (16b) divides his cases into five groups: 1. Operable, tumor movable with or without cutaneous attachment; no nodes. 2. Operable, same as 1 with (a) slight ulceration; nodes low in the axilla; (b) same as (a) with nodes high in the axilla and suspicious fullness and thickening in the supraclavicular fossa. (3) Inoperable, tumor, small or large, with or without cutaneous or fascial fixation and ulceration; nodes in the axilla, supravicular fossa and distant metastases. (4) Postoperative recurrence. (5) Postoperative prophylactic irradiation.

—To be continued next month

Alcohol and the Soldier

Civilians who provide facilities for normal entertainment and amusement can do much to prevent soldiers on leave from drinking too much, according to Major Merrill Moore, of the U. S. Army Medical Corps.

"Not alcohol, but the intemperate use of alcohol, is the problem in the Army as well as in civilian life," said Major Moore in a recent issue of the *Quarterly Journal of Studies on Alcohol,* the editorial offices of which are at Yale University.

CONTEMPORARY PROGRESS

MEDICINE

Chest Pains in Patients With Mitral Stenosis

A. M. BURGESS and L. B. ELLIS (*New England Journal of Medicine*, 226: 937, June 11, 1942) report 6 cases illustrating the different types of chest pain that may occur with mitral stenosis. The four types of pain that occurred in these cases were a cardiac neurosis, the pain of acute rheumatic carditis, angina pectoris, and so-called hypercyanotic angina. The pain of cardiac neurosis is of a very variable nature, usually felt in the apical region, but sometimes over the precordium; it has no relation to exertion and often persists for hours "or even days;" when this type of pain occurs with mitral stenosis it is associated with an anxiety state due to the patient's knowledge of heart disease and its dangers and with other neurotic symptoms. Patients with mitral stenosis who develop active rheumatic carditis during acute recurrences of rheumatic fever may develop chest pain during the acute attack, which is relieved when the acute symptoms subside; one such case is reported. True angina pectoris is rare in mitral stenosis, but may occur; one case of this type is reported. A severe type of precordial pain, sometimes called "hypercyanotic angina", usually occurs in advanced cases of mitral stenosis; the pain clinically resembles that of acute myocardial infarction, but is not accompanied by other symptoms of infarction—fever, leukocytosis and electrocardiographic changes. The accompanying cyanosis is often extreme and dyspnea and orthopnea severe, but the pulmonary congestion may be slight, as the attacks of pain are not necessarily associated with congestive heart failure. In the 3 cases of this type reported, the patients died during or immediately after an attack of pain of this type, but not at the time of the first attack. Autopsy was not permitted in one of these cases; in the other 2 cases there was no evidence of myocardial infarction.

COMMENT

This is a valuable contribution on the fine points of diagnosis of cardiac pain. No doubt many of those conditions are diagnosed as coronary artery disease.

M.W.T.

Intermittent Claudication: Its Treatment With An Insulin-Free Deproteinated Pancreatic Extract

T. J. FATHERREE and C. HURST (*Annals of Internal Medicine*, 17:325, August 1942) note that intermittent claudication—pain in the feet and legs after walking—is "a symptom and not a disease." In patients over fifty years of age, arteriosclerosis obliterans is the most frequent cause of intermittent claudication; in patients under forty-five years, thrombo-angiitis obliterans is the most frequent cause; other conditions that impair the arterial circulation of the extremeties and occasionally cause a severe anemia may also cause intermittent claudication. As in most instances the underlying cause is an obliterative arterial disease, which cannot be "eradicated," the treatment of intermittent claudication is difficult; it should aim to improve the circulatory deficiency. The authors have employed an insulin-free deproteinated pancreatic extract (depropanex) in the treatment of 15 patients with intermittent claudication, 9 of whom had thrombo-angiitis obliterans and 6 arteriosclerosis obliterans. In these patients the claudication time was determined by exercise with an apparatus by which the work performed per unit of time could be controlled. Depropanex was given by intramuscular injection. Of the 9 patients with thrombo-angiitis obliterans, 7 showed defi-

nite improvement as measured by the claudication time tests after five to ten injections; none of the 6 patients with arteriosclerosis obliterans showed definite improvement, but this series is small and others have reported improvement in patients with intermittent claudication of this type under treatment with depropanex. The authors found that there was "no method of predicting which patients will be improved excepting that of therapeutic trial." Further studies of this pancreatic extract in regard to optimal dosage are indicated. It was found that the intramuscular injection of 3 cc. of depropanex caused no marked changes in blood pressure, pulse rate or digital skin temperature.

COMMENT

I have been using depropanex for some time and find it effective in many instances. In some persons favorable results are noted only after months of treatment.
M. W. T.

Sulfadiazine in Pneumonia

H. K. ENSWORTH and associates at Bellevue Hospital, New York City (*American Journal of Medical Sciences*, 204:179, August 1942) report 239 cases of pneumonia treated with sulfadiazine, "the latest member of the sulfonamide group." The usual dosage was 2 gm. initially followed by 1 gm. every four hours. There were 26 deaths in the entire group of cases, a mortality rate of 10.9 per cent; if 8 deaths that occurred within twenty-four hours after treatment was begun are excluded, the mortality rate was 7.8 per cent (18 deaths in 231 cases). There were 42 cases of bacteremia with 13 deaths (30.9 per cent mortality). The fatality rate was much the same for all types of pneumococcus; there were only 3 deaths in 33 type III cases (9.1 per cent), and 2 of these occurred in less than twenty-four hours; the best results were obtained with type II cases, in which 13 of 42 patients showed bacteremia, but only 2 died, and one of these within twenty-four hours. Of 108 patients admitted to the hospital and treated early in the disease (in the first three days), only 7 died (excluding one twenty-four hour death), a mortality of 6.5 per cent; in the cases treated later the mortality was 8.9 per cent (also excluding twenty-four hour deaths). Only one death occurred among 113 patients under fifty-one years of age, excluding one twenty-four hour death. The incidence of serious complications in this series was low, empyema occurring in 8 cases and pneumococcus endocarditis in 2 cases, and a combination of the two conditions in one case; all patients with endocarditis died; 5 of the 8 who developed empyema recovered. There were few toxic reactions to sulfadiazine, although the blood concentration of the drug reached 7 to 9 mg. per 100 cc. Only 5 patients vomited, and 2 of these had vomited before the drug was given; 4 showed a moderate leukopenia, disappearing promptly when the drug was discontinued, and one a moderate anemia. There were 4 cases of drug rashes with fever and 2 of

"drug fever." Microscopic hematuria was found in 4 cases and renal colic with gross hematuria occurred in one case. Several patients showed temporary mental disturbances, which may have been due in part to the drug, but most of these patients were chronic alcoholics. Toxic reactions were definitely fewer with sulfadiazine than with sulfapyridine or sulfathiazole, while this drug appears to be about equally effective in the treatment of pneumonia.

COMMENT

Sulfadiazine seems the drug of choice in pneumonia. It can be used intravenously if bacteremia is present. The fact that it is less toxic than the other members of the sulfonamide group makes it more dangerous, as it were, because one is apt to be more careless in its administration. In older persons especially must one be on guard for renal disturbances, particularly interrenal tubular block due to acetylated crystals.

M.W.T.

The Clinical Aspects of Amebic Dysentery

W. SCHULZE and J. M. RUFFIN (*Southern Medical Journal*, 35:699, July 1942) present a study of 95 cases of proven amebic infection observed in Durham, North Carolina. Of the entire series of 95 patients, 89 had an active diarrhea when first seen; the remainder had liver or lung abscesses but no history of diarrhea could be elicited. Of the 89 patients with active diarrhea, 15 had some complication (amebic liver or lung abscess) or some coexisting disease. In the 76 patients with uncomplicated active diarrhea, the condition was chronic in most instances, 21 giving a history of spontaneous remissions, and 10 of remissions under treatment. The onset of diarrhea was gradual in most of these cases (71 per cent), but sudden in 18 instances. All of the 76 patients had observed blood in the stool and most of them had also noted the presence of mucus. The chief findings on physical examination were loss of weight and occasional abdominal tenderness; the temperature was above 38° C. in 10 patients, rising above 39° C. in 4 of these, although there were no clinical signs of either liver or lung involvement in any case. Proctoscopic examination was done in 61 of these 76 cases; it showed typical amebic ulcers in 52 cases. These ulcers are shallow and discrete with undermined edges and frequently covered by a gray exudate or mucus in which motile trophozoites are usually found. The mucosa between the ulcers is usually somewhat edematous but not inflamed. The authors note the difference between this "proctoscopic picture" and that characteristic of idiopathic ulcerative colitis, in which the mucosa is diffusely inflamed and the ulcers smaller ("pin point"). Anemia was not common in this group of patients with uncomplicated amebic diarrhea; only 8 showed hemoglobin below 70 per cent and 16 a red cell count below 4 million. The diagnosis in the 89 patients with active diarrhea was made by the demonstration in the stools of motile amebae containing red cells in all but 6 cases. In 2 of these 6 cases, biopsy of a rectal mass showed amebae; in the other 4 the proctoscopic examination showed the typical amebic ulcers which healed under specific therapy. Sixty-seven of the 76 patients with uncomplicated amebic diarrhea were treated by various drugs; carbarsone by mouth alone or in combination with chiniofon by rentention enema was most frequently employed; emetine was used in 4 cases in combination with chiniofon and in 4 cases in combination with carbarsone. The authors found the combination of carbarsone by mouth (0.25 gm. twice daily) and chiniofon (5 gm.) by retention enema the most effective in relieving the diarrhea, healing the intestinal ulcers, and rendering the stools negative. In cases of liver and lung abscess emetine was employed with good results; in 2 cases of liver abscess surgical drainage was also required. Forty-four of the patients with uncomplicated amebic diarrhea were followed up after treatment had been completed. Relapses occurred in 16 of the patients (36 per cent); the incidence of relapse was essentially the same with all the various methods of treatment employed. In this entire series of patients, there were only 2

whose diet was adequate and well balanced; the authors are of the opinion that dietary deficiency may be an important factor in the high incidence of relapses in this series. It is possible also that some of the relapses were in reality reinfections.

Proctoscopic examination for amebic ulcers seems a necessary diagnostic procedure. The treatment, to repeat, is carbarsone by mouth and chiniofon by retention enema. The general health of the patient must not be neglected.

M.W.T.

SURGERY

Local Sulfanilamide in Compound Fractures

N. K. JENSEN and M. C. NELSON (*Surgery, Gynecology and Obstetrics,* 75: 34, July 1942) found in animal experiments that sulfanilamide implanted locally was more effective in preventing wound infection than when given systemically; devitalized tissue and foreign particulate matter in the wound interfere with the prophylactic action of sulfanilamide. The animal experiments also showed that the local implantation of sulfanilamide is more effective against *Clostridium welchii* and *Clostridium histolyticum* than the administration of the drug by mouth or by injection; it is of little value against *Clostridium spetique* or *Clostridium oedematicus* by any method of administration. In the treatment of compound fractures at the Minneapolis General Hospital, débridement and immobilization are the basis of the treatment. Débridement is done under regional block or general anesthesia; local infiltration anesthesia is avoided. Foreign matter is removed and the depth of the wound explored to remove "all soiled and devitalized tissue;" frayed fascia and periosteum are excised and "the soiled ends of the bones" are rongeured. The wound is irrigated with warm normal saline solution, and again carefully explored by the surgeon to make certain that no devitalized tissue remains, as such tissue inactivates the sulfanilamide and furnishes "an excellent culture medium." Sulfanilamide powder is then distributed throughout the wound to cover all surfaces, employing 5 to 20 gm., and the wound is closed by interrupted silk sutures if this can be done without tension; if suture is impossible a larger amount of sulfanilamide (20 to 40 gm.) is "layered" over the surface of the wound and covered with vaseline gauze. Plaster is applied over this, as in Orr's treatment. When the fracture has been treated, for which skeletal traction is frequently employed, wounds are not dressed for three to five weeks, unless definite evidence of progressive infection develops. These same principles of treatment—débridement and immobilization—without sulfanilamide, were used for some time at the hospital, prior to 1938. Since the use of sulfanilamide was begun 212 compound fractures have been treated by the method described; in this group 7 primary and 2 secondary wound infections developed; 2 cases of gas gangrene necessitated secondary amputation; in both these cases débridement and irrigation of the wound had not been carried out thoroughly. The average hospital stay for the patients in this series was thirty days. In 96 cases of compound fracture previously treated at the hospital by débridement and immobilization without sulfanilamide, 25 developed infection; there were 7 cases of gas gangrene in 5 of which amputation was necessary. The average hospital stay for the patients in this series was 96.3 days. The use of sulfanilamide in addition to the "basic treatment" of compound fracture at the Minneapolis General Hospital has, therefore, reduced the incidence of all wound infections from approximately 27 per cent to 3.3 per cent, and of gas gangrene from 7.3 per cent to less than 1 per cent, while the average hospital stay of the patients was reduced by 70 per cent.

COMMENT

Experience at the Minneapolis General Hospital in the treatment of compound fractures undoubtedly justifies the use of sulfanilamide locally. The keystone of treatment in these cases is emphasized, viz: aseptic han-

dling, delicate technic, thorough debridement and adequate immobilization. The addition of sulfanilamide has undoubtedly reduced the incidence of complications, without in any way jeopardizing the patient immediately or remotely. Attention is called to the fact that this drug is much more potent and effective when used locally in these cases than when given systemically. The treatment of compound fractures is less controversial perhaps than it has been. Surgeons in this field are seeing "eye to eye" more frequently than formerly. Certainly the use of sulfanilamide locally is receiving wider acceptance as an adjuvant in the treatment of these cases.

T.M.B.

Influence of Abdominal Binders on Lung Volume and Pulmonary Dynamics

M. D. ALTSCHULE and N. ZAMCHEK (*Archives of Surgery*, 45:140, July 1942) report a study of the effect of abdominal binders such as are used routinely after abdominal operations on the "pulmonary function" of normal subjects and of patients with pulmonary congestion. It was found that the application of the binder was followed by the reduction of the volume of the functional residual air in normal persons and in 2 patients with pulmonary congestion; this reduction in the functional residual air was due to the reduction of the volume of the reserve air rather than to a decrease of the volume of the residual air. The volume of the vital capacity and of the total pumonary capacity was reduced by application of the abdominal binder in normal subjects and in the patients with pulmonary congestion; the reduction in total pulmonary capacity was most marked in the latter. Moderately tight and tight binders caused decreases also in the volume of the complemental air. These findings indicate that the application of tight abdominal binders after abdominal operations has a "deleterious effect" on respiratory function, favors atelectasis and impedes venous return. Patients with pulmonary congestion show evidence of a greater degree of respiratory embarrassment than normal persons, both according to "the measurements of this study" and clinical observation.

COMMENT

Any fixed and rigid routine in the preoperative or postoperative program is ill advised. "Rules are made to be broken." The patient above all things must be individualized. After all, he is the most important person at the operation. The conclusions drawn by the authors after their study would indicate that the use of abdominal binders following operations should be abandoned. The use of the abdominal binder has been growing less popular in recent years for a very good reason. Improvements in technic and operative management and better methods of anesthesia have insured a more comfortable postoperative course and less demand for a binder. When the various factors recognized as instrumental in favoring atelectasis and pneumonitis are present, trouble occurs, binder or no binder. The emphasis placed on the "ill effects of the binder" in this and other articles must not distract our attention from the many much more important factors active in producing postoperative pulmonary complications. Experience can recount occasions when the abdominal binder has been helpful rather than harmful.

But let us "soft pedal" routine in surgery.

T.M.B.

The Anaerobic Nonhemolytic Streptococci in Surgical Infections On a General Surgical Service

W. R. SANDUSKY and his associates (*Surgery, Gynecology and Obstetrics*, 75: 145, August 1942) report 29 cases of surgical infection due to anaerobic nonhemolytic streptococci, from the general surgical service of the Presbyterian Hospital, New York City. Of these 29 cases, 9 were perirectal abscess, 4 infected pilonidal cyst, 3 infected sebaceous cyst, 2 empyema thoracis, and 2 cholecystitis. One postoperative wound infection was due to anaerobic nonhemolytic streptococci. In all these 29 cases these organisms were isolated in pure culture; in 141 other cases of surgical infection on the same surgical service anaerobic nonhemolytic streptococci were isolated in association with other organisms, both anaerobic and aerobic. A review of the literature shows that this is the first report of the recovery of these organisms in pure culture from perirectal abscesses, and infected pilonidal and sebaceous cysts. From their study the authors conclude that anaerobic nonhemolytic streptococci are a part of "the normal flora" of the human mouth, intestine and female genital tract; they are usually harm-

less saprophytes, but it is evident that under certain conditions they can produce inflammatory processes in various tissues and organs. Adequate bacterial study of surgical infections should, therefore, include "a search for these organisms and other anaerobes," by routine anaerobic cultures.

The Blood Concentration and Urinary Excretion of Sulfadiazine Following Intraperitoneal Administration

J. D. RYAN, E. BAUMAN and J. H. MULHOLLAND (*Journal of The American Medical Association,* 119:484, June 6, 1942) report 6 cases in which sulfadiazine powder was "sprinkled into" the peritoneal cavity following operation; from 5 to 25 gm. of the drug was used in these cases. All the patients were adult males; in 4 cases the operation was a partial gastrectomy, in one an appendectomy and in one an exploratory laparotomy. None of these patients developed postoperative complications or showed any toxic symptoms from the intraperitoneal use of the drug. Studies of the concentration of the drug in the blood and urine showed that with the intraperitoneal application of 10 gm. of sulfadiazine, therapeutically effective concentrations of the drug were maintained in the blood for forty-eight hours; when larger amounts of sulfadiazine were used intraperitoneally (20 and 25 gm.), the effective blood concentration of the drug was maintained for longer periods (eighty-four and ninety-six hours). The peak of concentration of the drug in the blood is in all instances reached later than when sulfadiazine is given by mouth, indicating that the drug is well absorbed from the peritoneum, but not as rapidly as from the gastro-intestinal tract. As the effective therapeutic level of the blood is maintained for at least forty-eight hours with the intraperitoneal use of 10 gm. of sulfadiazine and it is "fairly certain" that the local concentration of the drug in the peritoneal cavity remains high for the same period of time, the authors consider that this amount is sufficient for "comparatively clean operative cases," such as those reported. When, however, the peritoneal cavity is "grossly contaminated" at the time of operation and peritonitis is widespread, larger doses (20 to 25 gm.) can be given without ill effects.

COMMENT

Experience in the use of the sulfonamide compounds intraperitoneally during abdominal operations is mounting. The effectiveness of these drugs when introduced in proper amounts is sufficiently established. A certain amount of confusion still exists as to the relative merits of the individual compounds. Sulfanilamide seems to receive universal acceptance. It is possible that sulfadiazine or perhaps another similar compound may supplant all others in this connection. Let us not "go all out" in the use of these miracle drugs. Clinical investigation, discriminating selection of case, honest evaluation of results —one and all must be satisfied if we are to make progress.

It is sometimes wise to "miss the band wagon."

T.M.B.

Postoperative Thrombo-Embolization

S. SHAPIRO, B. SHERWIN and H. GORDIMER (*Annals of Surgery,* 116: 175, August 1942) report a study of variations in the platelet count, the coagulation time and the plasma prothrombin time in 23 patients after surgical operations. In 8 of the 23 cases there was a reduction in the platelet count on the first to about the fourth day; in 15 of the 23 cases there was a rise in the platelet count beginning the fifth or sixth postoperative day and continuing for varying periods. The prothrombin concentration (or activity) was found to be low in the first few days after operation in some cases. In 14 of the 23 patients the prothrombin level or activity increased after the fifth postoperative day, as shown by the diminishing differences between the prothrombin time of the whole and the 25 per cent plasma; this usually occurred concomitantly with the increase in platelets, on the sixth to the tenth day after operation. Three of the 23 patients developed thrombophlebitis (with pulmonary infarction in 2 instances); the prothrombin concentration (or activity) was higher in these 3 cases than in any others of the series. This suggests that the increase in the coagulating substances of the blood is related to the development of postoperative thrombophlebitis. On this basis, 3, 3′ methylenebis (4 hydroxycoumarin), which acts as an anticoagulant by inhibiting or inactivating prothrombin

in man, has been given postoperatively when prothrombin estimations, made daily, show a progressive diminution of the difference between the prothrombin time of whole and 25 per cent plasma, if the difference is below 6 seconds for two successive days. The authors consider that it is not necessary to administer an anticoagulant to all patients after major surgical operations, but only when there is evidence of increasing prothrombin activity which has been found to indicate a tendency to thrombo-embolization.

COMMENT

Among the many postoperative complications "thrombo-embolization" becomes at once for the patient a grave menace, and for the medical attendant ample cause for alarm. The seriousness of its immediate and remote effects has engaged the attention of research workers both in the clinical and experimental fields. Among the varied etiologic factors emphasis has been placed on the role played by the following: trauma, infection, stasis, and biochemical changes resulting in interference with the normal phenomena of blood coagulation. The aspect presented by the last mentioned factor has in recent years received detailed study and attention, in consequence of which there have been suggested methods of therapy designed to offset the ill effect of such derangements. The present article is the result of such an effort and is to be welcomed. Attempts to solve this postoperative difficulty, no matter from what particular angle, lead to a better understanding of the entire clinical problem and so more surely improve the patient's chances. The use of prothrombin concentration values coupled with a proper evaluation of postoperative variations in platelet count may prove to be of some value in anticipating danger and suggesting the use of anticoagulants. Time alone will tell. In the meantime articles of this character put all clinicians and surgeons "on their toes." Experience has proved that there is a very definite program to initiate in these cases comprising hydration, mobilization, respiratory stimulation, prevention of increased abdominal tension, heat and, as indicated, sodium thiosulfate, hirudinization, and heparinization.

T.M.B.

UROLOGY

A Combined Tidal Irrigator and Cystometer for Management of the Paralyzed Bladder

W. V. CONE and W. H. BRIDGERS (*Surgery, Gynecology and Obstetrics*, 75: 61, July 1942) describe a combined tidal irrigator and cystometer, for the urinary bladder, which is a modification of Stewart's apparatus, simplified so that it can be used under war and other "adverse" conditions "without sacrifice of efficiency or control." It provides for tidal irrigation by alternately filling and emptying the bladder; it can be employed as a cystometer by closing off the siphon tube after the bladder has been emptied. As irrigating solution the authors employ autoclaved Ringer's solution or normal salt solution containing 0.3 per cent sulfanilamide, 0.03 per cent sulfapyridine and 0.3 per cent sulfathiazole; no evidence has been found to indicate that absorption of the sulfonamides occurs into the blood stream from the bladder irrigation fluid. For tidal irrigation the setting of the siphon loop of the apparatus is determined by cystometry; the height of the siphon loop must be "just below the level of the intravesical pressure produced by the amount of fluid which the bladder should contain before being emptied." In the treatment of the recently paralyzed bladder, the normal secretion of urine is "ignored" in determining the number of times the bladder is to be emptied per twenty-four hours, and only the number of emptyings is calculated that would be produced by the irrigating fluid dropping at a certain rate. If infection or much sediment is present in the bladder, the fluid should be allowed to drip more rapidly, "causing more frequent irrigations," than if these conditions are not present. This type of tidal irrigation is indicated chiefly in recently paralyzed bladders for the prevention or treatment of infection; also to increase the capacity of a contracted fibrotic bladder by gradually increasing the height of the siphon. It may be used whenever an indwelling catheter is indicated, with the advantage that it keeps the antiseptic solution in al-

most continuous contact with the bladder walls and prevents contracture. The indwelling catheter employed must be carefully adjusted so as to avoid traction on it; and changed, with irrigation of the urethra, every three days.

COMMENT

The advantages of this method and apparatus are these: (1) They combine measurement of capacity and therapeusis; (2) Variation and combination of antiseptics and stimulants; (3) Adjustment of the siphon loop so that overdistention is impossible; (4) Modification in accordance with the quality and severity of the infection. All in all they appeal to the conservatives as well worth trying. Radicals might have difficulties and do harm.

V.C.P.

Primary Carcinoma of the Ureter

L. E. McCREA (*Urologic and Cutaneous Review*, 46:485, August 1942) reports 2 cases of primary carcinoma of the ureter and presents an analysis of other cases reported in the literature. In the author's 2 cases, hematuria was the first symptom. Prior to admission to the hospital acute urinary retention developed in both instances. In both cases the growth originated in the lower third of the right ureter, projected through the ureteral orific and invaded the bladder wall. In one case there was marked destruction of the right kidney, although there was no history of renal pain or tenderness. In the other case, notwithstanding the ureteral obstruction, the retrograde pyelogram showed only "a slight hydronephrosis." The first patient died even with the aid of stimulating treatment. The second patient left the hospital before the study of his case was completed, or treatment begun. An analysis of the literature shows 161 cases of primary carcinoma of the ureter reported previously. The author's 2 cases bring the total to 163. In the reported cases the right side was more frequently involved than the left, and the lower third of the ureter was the most common site of the tumor. The most frequent pathological type of carcinoma in the reported cases was papillary carcinoma. In the author's first case, the growth was also found to be a papillary carcinoma. In the treatment of primary carcinoma of the ureter, radical removal of the ureter with the tumor is the best method of treatment. Since in most instances the tumor has invaded the bladder and produced some pathological condition in the kidney when the patient is first seen (as in the author's cases), the operation of choice is the radical removal of the kidney, the ureter and the involved portion of the bladder wall; this operation may be done in two stages, as the patient's condition is usually unfavorable for complete nephro-ureterectomy. In such cases a preliminary nephrectomy is done followed "in a reasonable time" by ureterectomy and partial cystectomy.

COMMENT

Someone has said that a very large part of medicine is involved in the mucous membranes. When the subject of cancer is in the picture this dictum is very largely true. If one adds the skin he is impressed with the fact that the epithelial structures, as surfaces, whether exposed to the air or infolded into the body in the intimate structure of organs or along passages such as the ureters, are the habitats of a very large number of cancers. As in almost all cancers early diagnosis and radical removal with irradiation before and after treatment are the only hopes. In the closed passages, such as the ureter, the question is, how shall the diagnosis be even reasonably early?

V.C.P.

Ureterocele; A Clinical Study and a Report of Thirty-Seven Cases

G. J. THOMPSON and L. F. GREENE (*Journal of Urology*, 47:800, June 1942) report 37 cases of ureterocele from the Mayo Clinic. In this series of cases 25 of the patients were females and 12 were males; the ages ranged from six to sixty-four years; most of the patients were between the ages of thirty and fifty years. The most frequent symptom was pain in the renal area, the lower abdomen or the groin (23 cases); the pain was also felt in the bladder at the end of micturition. Urinary symptoms such as frequency, dysuria and nocturia were present in 17

cases. Hematuria was noted in 13 cases. Five patients had no urinary symptoms, but in these cases a complete urological examination was done "in an attempt to find the cause of obscure abdominal symptoms," and the ureterocele was discovered. The ureterocele was located on the right side in 13 cases, on the left in 12 cases and was bilateral in 12 cases. Diagnosis was made by cystoscopy in all cases, the appearance of the ureterocele varying according to its size. Excretory urography was not found to be of much value in the diagnosis of ureterocele. The diagnosis could be established by this method alone in only 4 of 23 cases. The best form of treatment for uncomplicated ureterocele proved to be simple fulguration of a small ureteral orifice or a combination of ureteromeatotomy and fulguration of the walls of the ureterocele. Postoperative treatment for infection, which is almost invariably associated with ureterocele, is important. "Open operation" is indicated only if ureterocele is complicated by urinary calculi that cannot be removed by transurethral methods, or severe renal damage has resulted from urinary obstruction. From a review of the literature and their study of these cases, the authors conclude that the majority of ureteroceles are "of congenital origin," although some may be acquired.

Comment

The instructive points of this study concern the variations in the symptoms, the simplicity of cystoscopic diagnosis, and the safety of the treatment. With obstruction of outflow of urine absent the subjective symptoms are obscure or lacking; contrariwise, if obstruction is present they resemble those of stricture, which the ureterocele is in fact in those circumstances. One symptom of stricture not mentioned is occasional bed-wetting due to gush of the urine into the bladder, when the obstruction opens. Naturally the one great diagnostic means is the cystocope. Local surgery of minor character through the cystoscope to enlarge the natural opening or to produce a new one through the wall of the ureterocele is both inviting to the urologist and efficient for the patient. Permanence of benefit rests on regular examinations and occasional repetition of the surgery, because all such artificial openings tend to close.

V.C.P.

Intravenous Urography; A Test of Renal Function

T. FINDLEY and his associates at Washington University School of Medicine (*Journal of Urology*, 48:119, July 1942) describe a method for employing intravenous urography as a renal function test by determining the quantity of iodine excreted in the urine under standard conditions. This procedure does not complicate the radiological technique of intravenous urography; the last x-ray film is usually made about thirty minutes after the contrast medium is injected. When the iodine excretion is to be determined as a test of renal function, this last film must be made so that the patient finishes voiding urine exactly thirty minutes after the injection of the contrast medium is completed. The opaque media used by the authors are diodrast, which contains 175 mg. iodine per cc., and diodrast compound which contains 250 mg. iodine per cc. A minimum dose of the opaque medium, 0.5 cc. per kg. body weight, is suggested, but whatever dose is used, the amount of iodine injected can be accurately calculated. The amount of iodine excreted in the urine thirty minutes after the injection of the diodrast is determined by the method of White and Reid; this technique is simple and very similar to that of blood sugar determination except that no protein precipitation is required. In the authors' use of this test they found that normal subjects excrete 45 per cent of the amount of iodine injected in thirty minutes. In their preliminary experiments, urea clearance tests were done on the same patients and it was found that reduction in the rate of iodine excretion was "roughly proportional" to the changes in urea clearance. The use of the iodine excretion test in association with intravenous urography has the added advantage of requiring no blood analysis.

Comment

An advantage of this procedure is that it may be carried out at the same time as radiology. A limitation is that it shows the total function of both kidneys during the same half-hour. Obviously, one of the older

procedures is required for the separate function of the two kidneys. Total function is, however, a very desirable check-up because not infrequently ureteral catheterization gives contradictory findings in that the better kidney may show the poorer excretion at a given test. Hence such separations must be repeated for verification.

V.C.P.

Carcinoma of the Prostate Treated With Diethylstilbestrol

N. J. HECKEL and H. L. KRETSCHMER (*Journal of the American Medical Association,* 119:1087, August 1, 1942) report a case of carcinoma of the prostate in a man fifty-nine years of age. The chief symptoms were intermittent hematuria, difficulty of urination, headache, leg pains and loss of weight. In the last six weeks prior to admission to the hospital daily catheterization had been necessary to relieve urinary retention. There was a "well defined secondary anemia." A transurethral resection was done, which relieved the urinary obstruction. The prostatic tissue removed showed adenocarcinoma grade 3. Three weeks after the patient's discharge from the hospital, diethylstilbestrol therapy was begun with a daily dose of 3 mg. gradually increased to 12 mg. The leg and back pains were relieved within ten days. The anemia improved and there was a considerable gain in weight. On rectal examination, the induration of the prostate was found to be much softer. At the end of two hundred and twenty-three days, when the total dosage of diethylstilbestrol had reached 1,546 mg., the patient was readmitted to the hospital for two days, and prostatic tissue was removed for histological study by transurethral resection. This showed a widespread change in the cells of the neoplasm, characterized by hydropic degeneration and vacuolation. As the patient had been given no other treatment, the clinical improvement, the softening of the prostate, and the corresponding histological change in the neoplasm must be attributed to the administration of diethylstilbestrol.

COMMENT

If this observation is established for cancer in any organ and for a majority of types of cancer, then diethylstilbestrol will rival in its benefits surgery, radium and x-ray. Its manifest advantage may be that in circulating in the blood its action continues until it is excreted after administration ceases. This prospect is certainly alluring.

V.C.P.

PEDIATRICS

Pallor and Anemia in Adolescents

J. SCHWARTZMAN (*Archives of Pediatrics,* 59:466, July, 1942) presents a study of the relation of pallor to anemia in high school students (thirteen to nineteen years of age); many physicians have pointed out that these two are "often dissociated," although the popular belief persists that pallor is definite evidence of anemia. Of the 943 adolescents examined, 471 were males and 463 females; red cell counts and hemoglobin determinations were done in all. A definite facial pallor was noted in 106 cases (36 males, 70 females), but of these only 22 had definite anemia on the basis of the blood findings, i.e., hemoglobin below 13 gm. (80 per cent) or red cells below 4 millions. In the remaining 84 cases of pallor, the blood findings were within normal limits, averaging 14.1 gm. hemoglobin and 4.84 million red cells. On the other hand the blood counts showed a definite anemia in 84 of these adolescents (8 males and 76 females) who had no detectable pallor. If pallor had been depended on for the diagnosis of anemia, or as "a screening index" of anemia, these cases would have been missed. No definite cause for the occurrence of pallor without anemia in these cases could be determined. In the entire group studied there were 106 cases of anemia, 96 in females, an incidence of 20.7 per cent for the female adolescents and 2.1 per cent for the males. Of these 106 anemic subjects, 104 showed de-

creased hemoglobin, 14 diminished red cell counts; reduced red cell counts were associated with diminished hemoglobin in all but 2 cases. Hemoglobin determination, therefore, may be considered the best method of detecting anemia in adolescents in cases where it is impossible to do a complete blood count. In this study the hemoglobin determination would have given a correct diagnosis in 98.1 per cent; and it is evidently a "highly efficient screening method" for the detection of unsuspected anemia in children of high school age.

Salicylate Prophylaxis in Rheumatic Fever

A. F. COBURN and L. V. MOORE (*Journal of Pediatrics,* 21:180, August 1942) report a study of 186 rheumatic children before and following hemolytic streptococcus pharyngitis. In these patients, throat cultures were made routinely during the fall and winter months. Each patient was instructed to notify the hospital at the onset of pharyngitis; on such notification, salicylate therapy was instituted, and a throat culture made. If the culture showed hemolytic streptococcus group A, the salicylate prophylaxis was continued for four weeks; the daily dosage was 4 to 6 gm. of sodium salicylate, according to the size of the patient. There were 47 patients who received sodium salicylate according to this routine from the onset of an attack of hemolytic streptococcus pharyngitis. Only one of these patients developed a typical rheumatic attack; the symptoms yielded promptly to salicylate therapy, showing that this patient was not refractory to the drug, and "suggesting the possibility that prophylaxis had not been carried out as advised." None of the other patients developed any symptoms of a rheumatic attack, although 15 showed a temporary rise in the red cell sedimentation rate a few days after the salicylate was discontinued. One hundred and thirty-nine patients developed a hemolytic streptococcus pharyngitis but failed to give notification during the early phase and were therefore not given salicylate prophylactically; 57 of these patients developed typical rheumatic fever. These results indicate that the administration of salicylate during a hemolytic streptococcus infection of the respiratory tract and "the silent phase" in rheumatic patients is of definite value in the prevention of attacks of rheumatic fever in these patients.

Ratio of Cardiovascular Malformations to Other Types of Heart Disease of Children

J. H. WALLACE (*American Journal of Diseases of Children,* 63:1096, June 1942) presents an analysis of 598 children attending a cardiac clinic; 239, or 40 per cent of this group, showed definite heart disease. In 90 (37.6 per cent) the cardiac disease was "on a congenital basis." In children in the first three years of life, all cases of heart disease were of the congenital type; the incidence of congenital heart disease in relation to all types of heart disease declined in the older age groups—to 11 per cent in children in the thirteenth year of life. Of 185 children of school age (six to thirteen years) with definite heart disease, 47, or 25.4 per cent, had congenital heart disease. Of the 90 children with congenital heart disease, 14 showed cyanosis, but none of the children in the first two years of life showed this symptom. The incidence of rheumatic heart disease increased in the older children as those previously uninfected acquired rheumatic infection. The incidence of congenital heart disease in the group studied is, however, "comparatively high" for an area in which rheumatic fever is prevalent (Chicago, Ill.).

Spastic Children in an Outpatient Psychologic Clinic

OLGA BRIDGMAN (*American Journal of Disease of Children,* 64:11, July 1942) reports that during the past five years 123 spastic children were studied at the children's psychologic clinic of the University of California Medical Center. In 10 of these cases, there was a definite history of a severe illness, after which the paralysis, and in some cases epileptic seizures, persisted; in these cases, there

was, therefore, definite evidence of an "inflammation in the brain" as a cause of the paralysis. In the remaining 113 patients, a special study of the history was made to determine the importance of birth injuries as a factor in the causation of spastic paralysis. It was found that prolonged labor was significantly more frequent in the history of the spastic children than in a control group of 500 children born in the hospital. The use of forceps in delivery, whether labor was prolonged or not, was four times as frequent in the spastic group as in the control group; premature births and abnormal presentations were also more frequent in the spastic group. Over half the spastic children were first-born, and it is generally considered that first-born children are more apt to suffer injury at birth than the children of subsequent pregnancies. In this series it was found that prolonged labor and instrumental delivery were much more frequent in the first-born spastic children than in the whole spastic group.

There were 23 spastic children in whom the history showed normal delivery at term with no evidence of the possibility of birth injury. In most of these cases, no abnormality was noted by the parents until the child failed to sit up, walk or talk normally; in other cases "slight convulsive attacks" occurred at three to six months followed by definite spastic paralysis. Examination of this group of children, however, showed the presence of other anomalies of development, such as club feet, multiple lipomas, or hyperostosis of cranium, in several instances. This would indicate, in the author's opinion, that children of this group had some "basic defect" or abnormality not attributable to birth injury. It is also possible that abnormal presentations, prematurity and prolonged labor evident in the history of the larger group of spastic children may also depend upon other "more fundamental conditions," so that it is impossible to determine "the true basic cause of the abnormality of any spastic child."

The Chemotherapy of Infantile Diarrhea; A Comparison of Sulfathiazole and Sulfaguanidine

R. B. TUDOR *(Journal of Pediatrics,* 20:707, June 1942) reports 31 cases of infantile diarrhea treated with sulfathiazole or sulfaguanidine. Sulfathiazole was used in 16 cases and sulfaguanidine in 15 cases; the dosage of sulfathiazole for infants under one year of age was 1 gm. (15 grains) as an initial dose followed by 0.25 gm. (4 grains) every four hours; the initial dose of sulfaguanidine was 2 gm., the subsequent dosage 0.5 gm. every four hours. The dosage of both drugs was doubled for children over one year of age. Treatment was continued to the fourth or fifth day after diarrhea and other signs of infection had subsided. Only 2 patients showed any toxic reaction in the form of prolongation of fever by sulfathiazole, until the drug was stopped. Clinically 16 infants had bacillary dysentery and 15 "parenteral diarrhea," secondary to infection elsewhere, usually in the upper respiratory tract, but stool cultures were consistently negative in both groups. Three patients (one with bacillary dysentery and 2 with parenteral diarrhea) did not show satisfactory improvement on sulfaguanidine and were changed to sulfathiazole, with prompt benefit. Otherwise the two drugs were equally effective in relieving symptoms and shortening the course of the disease, whatever the degree of dehydration. In addition to these 31 patients 4 children with a history of severe diarrhea were admitted to the hospital in a state of collapse and died within a few hours before sulfonamide therapy was given. One case of typhoid fever and one of paratyphoid A in infants were treated with sulfathiazole and 2 cases of paratyphoid A fever with sulfaguanidine. In all these cases the sulfonamide used "seemed to have been beneficial in checking the diarrhea."

Medical BOOK NEWS

Edited by
ALFRED E. SHIPLEY, M.D., Dr. P.H.

All books for review and communications concerning Book News should be addressed to the Editor of this department, 1313 Bedford Avenue, Brooklyn, N. Y.

Smith & Gault's Pathologic Text Revised

Essentials of Pathology. By Lawrence W. Smith, M.D. and Edwin S. Gault, M.D. Second edition. New York, D. Appleton-Century Company. [c 1942]. 904 pages, illustrated. 4to. Cloth, $10.00.

THE success and value of any medical textbook are undoubtedly proved by the publication of a second and succeeding editions within comparatively short intervals of time. The fact that *Essentials of Pathology* by Smith and Gault has been reissued in a second edition naturally presupposes that it belongs in the category of successful texts. Undoubtedly subsequent judicious revisions in the future will place it on a par or even on a superior position among single volume textbooks of pathology that have long enjoyed favoritism as recommended books for medical schools, pathological departments of hospitals, and the general medical profession.

In this second edition the authors have in great part elaborated the purely didactic text dealing with general pathology, and much improvement is observed in the section devoted to special pathology. The continued inclusion of case histories, albeit abridged and of the blank pages for notes is highly commended.

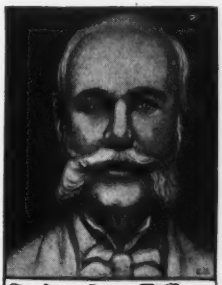
There are no pretensions on the part of the authors to present their textbook as an Encyclopedia of Pathology. It is intended primarily for medical students and the younger men intending to specialize in pathology.

Among the best chapters in the book are those dealing with inflammation, granulomata, oncology, and cardiovascular diseases.

Throughout the text is concise and to the point; the illustrations, particularly histological, are with few exceptions excellent. Perhaps a subsequent edition will carry more gross pathological illustrations.

Taken all in all the Smith and Gault textbook entitled *Essentials of Pathology* can be highly recommended to students and the general medical profession interested in the morbid anatomy and physiology underlying disease processes.

W. W. HALA



Carlos Juan Finlay
1833 - 1915

Classical Quotations

● On the 30th of last June [1881], I took to the Quinta de Garcini a mosquito which had been caught before being allowed to sting, and there made it bite and fill itself with blood from the arm of a patient, Camilo Anca, who was in the fifth day of a well characterized attack of yellow fever of which he died two days later. I then picked out F. B., . . . and made the same mosquito bite him. . . . on the 14th [of July] he was admitted to the Military Hospital with a mild attack of yellow fever. . . .

Carlos Juan Finlay
***Anales de la Academia de Ciencias Medicas, Fisicas y Naturales de la Habana,* Vol. XVIII, p. 147, 1881.**

Charaka Club's Latest Volume

The Proceedings of the Charaka Club. Volume X. Baltimore, Williams & Wilkins Company, [c. 1941]. 260 pages, illustrated. 8vo. Cloth, $5.00.

THE present volume contains a number of papers presented before the Charaka Club in 1938, 1939 and 1940. They vary greatly both in quality and interest, ranging from short occasional pieces, that certainly do not deserve to be perpetuated in print, to significant historical or philosophical contributions. Among the more interesting papers may be mentioned W. Osler Abbott's *The Problem of the Professional Guinea Pig.* Walter Mendelson's *Recollection of Henry George,* and Walter R. Steiner's *A Physician's Ex-*

periences During the Civil War, All in all good summer reading.

GEORGE ROSEN

Vitamin Chemistry

Chemistry and Physiology of the Vitamins. By H. R. Rosenberg, Sc.D. New York, Interscience Publishers, Inc., [c. 1942]. 674 pages, illustrated. 8vo. Cloth, $12.00.

TO date this book is the most thorough in the description of the chemistry of the vitamins and their physiology that a physician can use for reference.

The latest detailed information about the vitamins, their origin, synthesis, present clinical use and other incidental information, are covered. Tests now available for every vitamin are given at the end of each chapter. The industrial methods of preparation are described.

The book contains a unique feature, a patent index. This index lists all of the vitamins, processes, the countries in which these patents have been issued and to whom they have been issued. This information will, no doubt, be of great help to biochemists in this field as well as to research institutions. The authors and subjects indices are complete.

The book is a worthwhile addition to the literature on vitamins.

MORRIS ANT

Future Medical Practice Appraised

America Organizes Medicine. By Michael M. Davis. New York, Harper & Brothers, [c. 1941]. 335 pages. 8vo. Cloth, $3.00.

WHETHER one agrees with the author's conclusions or not, the book is a valuable addition to the list of those devoted to the subject of changes in our present system of medical practice.

It seems quite apparent that the world cataclysm will effect the lives of most of us in many ways. As physicians, we are, of course, particularly interested in the effects of social and economic changes on medical progress and medical practice, as they relate to our own lives as well as to the health and well being of the community.

Every physician, regardless whether he be specialist or general practitioner, in independent practice or on a salary basis, in a teaching position or in government service, must be vitally interested in the changes which appear on the near horizon. The reviewer knows of no other book which so completely discusses the present status of medical practice with its varied ramifications, so little known to the average man, as does this one. It should be read by proponent as well as opponent of the theories and conclusions indulged in by the author.

BENJAMIN M. BERNSTEIN

Cabot's Latest Diagnosis

Cabot and Adams Physical Diagnosis. By F. Dennette Adams, M.D. Thirteenth edition. Baltimore, Williams and Wilkins Company, [c. 1942]. 888 pages, illustrated. 8vo. Cloth, $5.00.

A NEW edition of this classic has now appeared. As in the past it can be recommended as one of the best works on physical diagnosis of which we know.

Some of the most outstanding clinicians and teachers in Boston have contributed to make this book readable, meaty, and up to date.

ANDREW M. BABEY

Nursing for Health

Everyday Nursing for the Everyday Home. By Elinor E. Norlin, R.N., and Bessie M. Donaldson, R.N. New York, The Macmillan Company, [c. 1942]. 306 pages, illustrated. 8vo. Cloth, $2.50.

THE title of the book explains its object which is well fulfilled by the authors who have had many years of nursing and teaching experience.

Attention is given to the conservation of health as well as to the care of the sick. Part one, dealing with this topic, and part two, on nursing when illness comes, contain much sound advice which should be helpful, especially at this time.

WILLIAM E. MCCOLLOM

Medical Politics and Medical Ethics in a Novel

Dr. Finlay Sees It Through. By Alan Hart. New York, Harper & Brothers, [c. 1942]. 370 pages. 8vo. Cloth, $2.50.

THIS is a novel by a doctor, with three other books to his credit. It is the story of Dr. John Douglas Finlay who practiced medicine in a coast town in Oregon, where he had his own private hospital. He sold

out just about the time of the Big Depression and went to Europe for study and pleasure. In 1932 the hospital was burned down and its new director murdered. Dr. Finlay now returned to Newland and, in spite of the problems incident to the depression, started to rebuild and reestablish his practice and organized the first COOPERATIVE MEDICAL Group in his county. This type of practice failed to meet with the approval of the County Medical Society and his membership was forfeited and even his state license to practice was threatened. The opposition contained many men who were definitely fragile, both ethically and professionally. How Dr. Finlay was restored to his well deserved position in the community is the story, and well worth the reading. The romance of the novel has to do with the lives and the loves of the assistants of Dr. Finlay most of whom courageously stuck by their chief when the going was stormy and rough. Dr. Finlay had lost his wife and child early in his practice, but at fifty, he is being readied for a new life with the head nurse of the hospital, a fine type of woman, wise, efficient and faithful.

JOSEPH RAPHAEL

American Tropical Medicine

Ambassadors in White. The Story of American Tropical Medicine. By Charles M. Wilson. New York, Henry Holt and Company, [c. 1942]. 372 pages, illustrated. 8vo. Cloth, $3.50.

THIS book is a conscientious, uncritical, and far from distinguished attempt to depict in popular language the distressing toll of death from preventable diseases among our Central and South American neighbors, with its consequent inroads upon the attainment of genuine Inter-American solidarity and prosperity. In the author's own words: "There are somewhere around a hundred and twenty million people in Latin America, from the Rio Grande to Cape Horn. At this very moment it is a good bet that at least fifty million of them are sick. Sick of almost all the diseases that we in the United States encounter in our own lives, and of a multitude of savage and highly fatal diseases about which we know almost nothing." This sets the tempo of the underlying motif, which is developed by devoting a long series of chapters to the discoveries and achievements of physicians and scientists who have labored for the amelioration of health hazards among our neighbors to the south of us. These are the "ambassadors in white," and the roll of honor includes the names of such world famous men as Gorgas, Finlay, Reed, Lazear, Noguchi, and lesser known men such as Aguilar, the Guatemalan surgeon, and Deeks, the Canadian born pioneer in problems of nutrition and malnutrition in the American Tropics. The final chapters are devoted to a quite general consideration of such diseases as Oroya Fever, Pinta, Ainhum, Typhus, Chagas Disease, the Dysenteries, Yaws, Hookworm, Leprosy, Pellagra, and Malaria. Towards the end there is a chapter entitled "Damn the Mosquitoes," as well as one titled "Banana Medicine," the latter being concerned with the medical activities of the United Fruit Company in Central America.

The book is a singular composite of fairly well presented fact and mis-statement. Under the latter category fall such pronouncements as: "Bubonic plague, the louse-carried nemesis of medieval Europe" (p. 19) Reference, on page 45, to the causative bacteria of malaria and hookworm. "Noguchi propagated the micro-organisms discovered in the brains of rabid dogs." (p. 192) "He (Noguchi) considered the newly discovered parasite of yellow fever, a simple spore-bearing organism. Perhaps this, at last, was the true causal agent of yellow fever." (p. 206) "Noguchi, perhaps the greatest bacteriologist the world has ever known." (p. 207). "On the whole the mosquito remains an enigma with which those still toddling sciences called entomology and bacteriology are not yet able to cope." (p. 255).

Altogether, this is a book with considerable popular appeal, especially for that large class of educated laymen who are interested in the glamorous subject of tropical diseases, and are willing to have tropical medicine served to them in a highly popularized, exuberant, and uncritical fashion, but scarcely a book for the not inconsiderable numbers of physicians, and

public health workers, who possess knowledge drawn from first-hand sources of the monumental contributions of such immortals as Gorgas, Reed, Lazear, Finlay, and others of their ilk.

WADE OLIVER

Psychologic Treatment

Psychotherapy In Medical Practice. By Maurice Levine, M.D. New York, The Macmillan Company, [c. 1942]. 320 pages. 8vo. Cloth, $3.50.

THE author of this book is a well known psychiatrist with a large psychiatric experience. The book is thoroughly practical. Primarily intended to aid the general practitioner in treating mild cases of mental disorder in his practice, it describes simple everyday methods which should cause the reader no difficulty to comprehend and apply. In fact, the methods and their application are so simple that some may question that physicians and intelligent laymen generally should stand in need of such information. The book, however, will serve a useful purpose in demonstrating the need and ability of every physician to help his patients in uncomplicated cases to adjust themselves in life's vicissitudes. One doubts, however, whether the general practitioner, unless specially interested in psychiatric problems, will have the patience and find the time to minister to his psychotic patients.

JOSEPH SMITH

Sex Education

Sex Guidance in Family Life Education. A Handbook for the Schools. By Frances B. Strain. New York, The Macmillan Company, [c. 1942]. 340 pages. 8vo. Cloth, $2.25.

THIS book, written at the request of educators for a guide to sex education in the schools, serves its purpose well. It represents a practical way of handling delicate problems which arise in the average household. Though it offers no scientific information, it may be of value to the medical profession. The method of approach and the psychological reactions are dealt with adequately. Behavior problems are dealt with intelligently.

This book is recommended for use by every individual engaged in child welfare.

IRVING GREENFIELD

BOOKS RECEIVED *for review are promptly acknowledged in this column; we assume no other obligation in return for the courtesy of those sending us the same. In most cases, review notes will be promptly published shortly after acknowledgment of receipt has been made in this column.*

A Textbook of Gynecology. By Arthur H. Curtis, M.D. Fourth edition. Philadelphia, W. B. Saunders Company, [c. 1942]. 723 pages, illustrated 8vo. Cloth, $8.00.

The Hand, Its Disabilities and Diseases. By Condict W. Cutler, Jr. M.D. Philadelphia, W. B. Saunders Company, [c. 1942]. 572 pages, illustrated. 8vo. Cloth, $7 50.

Mind: Perception and Thought in Their Constructive Aspects. By Paul Schilder. New York, Columbia University Press, [c. 1942]. 432 pages. 8vo. Cloth, $5.00.

Synopsis of Pathology. By W. A. D. Anderson, M.D. St. Louis, C.V. Mosby Company, [c. 1942]. 661 pages, illustrated. 12mo. Cloth, $6.00.

Shock: Its Dynamics, Occurrence and Management. By Virgil H. Moon, M.D. Philadelphia, Lea & Febiger, [c. 1942]. 324 pages, illustrated. 8vo. Cloth, $4.50.

Advances in Pediatrics. Editor, Adolph G. DeSanctis, M.D. Volume 1. New York, Interscience Publishers, Inc., [c. 1942]. 306 pages. 8vo. Cloth, $4.50.

Emergency Care. By Marie A. Wooders, R.N. and Donald A. Curtis, M.D. Philadelphia, F. A. Davis Company, [c. 1942]. 560 pages, illustrated. 8vo. Cloth.

Clinical Anesthesia. A Manual of Clinical Anesthesiology. By John S. Lundy, M.D. Philadelphia, W. B. Saunders Company, [c. 1942]. 771 pages, illustrated. 8vo. Cloth, $9.00.

Civilian Health in Wartime. By Francis R. Dieuaide, M.D. Cambridge, Harvard University Press, [c. 1942]. 328 pages. 8vo. Cloth, $2.50.

A Manual of Roentgen Diagnosis. By Kenneth S. Davis M.D. San Francisco, J. W. Stacey, Inc., [c. 1941]. 160 pages, 4to. Cloth, $3.50.

Roentgen Treatment of Diseases of the Nervous System. By Cornelius G. Dyke, M.D. and Leo M. Davidoff, M.D. Philadelphia, Lea & Febiger, [c. 1942]. 198 pages, illustrated. 8vo. Cloth, $3.25.

Problems of Ageing, Biological and Medical Aspects. Second edition. Edited by E. V. Cowdry. Baltimore, The Williams & Wilkins Company, [c. 1942]. 936 pages, illustrated. 8vo. Cloth, $10.00.

The Biological Action of the Vitamins: A Symposium. Edited by E. A. Evans, Jr. Chicago, The University of Chicago Press, [c. 1942]. 227 pages, illustrated 8vo. Cloth, $3.00.

Aftereffects of Brain Injuries in War. Their Evaluation and Treatment. The Application of Psychologic Methods in the Clinic. By Kurt Goldstein, M.D. New York, Grune & Stratton, [c. 1942]. 244 pages. 8vo. Cloth, $4.00.

The Mayos. Pioneers in Medicine. By Adolph Regli. New York, Julian Messner, Inc., [c. 1942]. 248 pages, illustrated. 8vo Cloth, $2.50.

Manual of Human Cross Section Anatomy. By Dudley J. Morton, M.D., Raymond C. Truex, M.S. and Carl E. Kellner. Baltimore, Williams & Willkins Company, [c. 1941]. 249 pages, illustrated. Folio. Cloth, $6.00.

Medical Times

The Journal of the American Medical Profession

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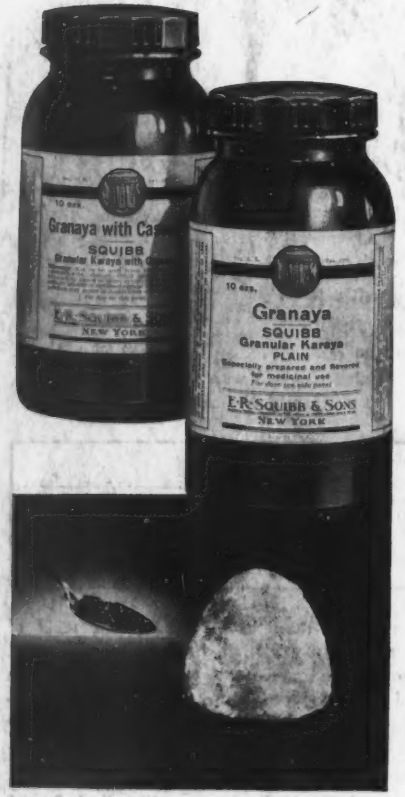

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